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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Wednesday 29 January 2014

Journal des débats (Hansard)

Mercredi 29 janvier 2014

Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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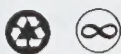
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Wednesday 29 January 2014

Mercredi 29 janvier 2014

*The committee met at 0804 in the Crystal Ballroom, Walper Hotel, Kitchener-Waterloo.
[Failure of sound system.]*

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

PEACEWORKS

Ms. Joanne Young Evans: —and demonstrates a high degree of alignment. In particular, this model is built upon all of the philosophical and policy prerequisites. It is designed to maximize system capacity to ensure a full range of services within a sustainable framework. Fundamental to its design is a shared commitment to a holistic, psychosocial, client-centred, evidence-based model of care and the decision-making process.

In promoting highly coordinated administrative and clinical structures and practices, it offers a more cohesive administrative structure, integrated information systems and significantly improved capacity to develop strong linkages with CCACs, primary care, hospitals and other social and human services.

At 8:45 a.m., you will be hearing from Dale Howatt, executive director of Community Support Connections—Meals on Wheels and More. Ms. Howatt will be demonstrating how integration and mergers do work, save money, increase capacity and provide excellent services for Ontario's seniors and people with permanent disabilities living in their own homes, living independently and with dignity as long as is safely possible, as evidenced by the following graph.

This committee must recommend that LHSIA be strengthened, resulting in a more effective and efficient health care system to serve Ontario residents now and well into the future.

Thank you for your time, energy and understanding of this critical cornerstone in putting Ontario residents first.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about eight minutes left. With that, we'll start with the official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming today. Excellent presentation. The purpose of this—I'm not sure if you've been following the Hansard of all the things that people are coming in with. We're getting a bit of a theme right now that has been coming in.

Your last comment here, saying to strengthen, "resulting in a more effective and efficient health care system": As an MPP, I can say that all of us chat at times, and CCACs and LHINs in our area—there doesn't seem to be a flow of consistency of the resources that each one needs. They don't seem to go hand in hand. Everyone has different experiences with each of them.

We're clearly seeing here today, and during the last meetings that we've had, that unless we all push from behind and all work together—that's going to be the key component of making things successful.

Just listening to Gordon and Martina about their strategy and plan, do you not think it would be helpful if those resources and strategies went from each LHIN and CCAC to strengthen them? How do you see the strengthening, I guess is my question to you.

0830

Ms. Joanne Young Evans: One of the things that needs to occur is that the LHINs have to be able to integrate organizations much more quickly and much more effectively and efficiently, without the potential of political fallout and threats of court action etc.

We understand the LHINs are in place in 14 areas to deal with the contextual issues in each of those areas, and they do a very good job of that, hence why it's so different in every LHIN. But what we have here is a waste of funding—at least to 30%—not only in our LHIN, but in LHINs across this province, on administration of numerous organizations that truly do not need to exist.

I think that the LHIN is doing an expert job at strategizing and policy-making. What's happening: The CCACs are directing many of the services, but only have so much control.

One of the issues that we talked about a year ago was that eventually the organization that we would create from community support services may, in fact, then become linked with the CCAC, and the CCAC then becomes bigger. I'm not suggesting regional health centres. Alberta is proof that that doesn't work very well. However, we must do a better job at not wasting the resources we have.

The wait-lists, I can tell you: up to eight years for certain services. Not only is that unacceptable; it's abysmal for a nation such as Canada and a province such as Ontario.

So you need to be able to decrease the amount that's being spent on administration and increase what's being

spent to the front line. Integration is one of the ways to do that.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much. Third party: Ms. Fife.

Ms. Catherine Fife: Thank you very much, and, Joanne, thanks for the presentation. I think the matrix of services that you provided on page 3 is actually a good indication of the work that's in front of us. You do mention on page 2, though, that the Attorney General's office has already concluded that LHINs do have the power to force integration, and yet obviously there's a reluctance to do so. We are seeing this in various stages across the province.

Ms. Joanne Young Evans: One of those reasons would be that they don't want to waste taxpayers' dollars in court. I respect the LHINs for that, and I think that that's a good decision.

Ms. Catherine Fife: So your recommendation, though, is for this committee to go back and be supportive of a direction around forced integration, even if there's a cost?

Ms. Joanne Young Evans: But if you eliminate the court action, then the costs of actually integrating in the LHIN is eventually your return on investment; as will be proven by Ms. Howatt when she comes up, it will actually decrease your costs in the end.

Ms. Catherine Fife: And I think that a strong case could be made for integration.

You do mention that there's been some improvements in transportation and the services around Alzheimer's. I'm hearing that this is actually an emerging and growing issue, across the province. The finance committee just finished travelling across the province. We need to plan for this. Would you agree?

Ms. Joanne Young Evans: I would, and Alzheimer's is probably an excellent example in our area of three smaller organizations coming together as one. So they've done a very good job of doing that. It took them three to four years to finally get there, and I guess that's the speed I'm talking about. It was voluntary, which was wonderful.

The transportation piece: What's happening is that there are organizations that are giving their transportation services over to other organizations. Again, they're larger organizations, and it does make sense. You probably couldn't do any better in those areas, but some of these organizations are really quite small, and you can see basically the patchwork quilt of what exists. So you can imagine the thousands of hours, both in administration and in volunteer time, that really could be put to better use.

Ms. Catherine Fife: Thank you for coming forward, and putting forward a theme of residents over organizations. I appreciate it.

The Chair (Mr. Ernie Hardeman): Thank you very much. For the government, Mr. Colle.

Mr. Mike Colle: Thank you for all the work that you've done and your staff—they're responsible. It's obviously a very thoughtful process here. The graphs

really help. I think it's one of the few presentations we've had with this type of visual support, so it's very, very welcome.

I guess the real dilemma, though, is that what you're saying is almost counterintuitive, because everybody really treasures their local, non-profit organizations. Everybody treasures their local hospital. So when a LHIN comes around and says, "Well, listen, we can deliver better service, more effectively and efficiently, if we do some coming together"—alliances, or whatever it is, like they did with the Alzheimer's—Dementia Alliance, I think, they call themselves.

So if government then has given the LHIN the power, you can see it really is still very problematic, because the reality of trying to implement this—you know, the end of these traditional enclaves.

I'm almost saying to you that it's easy to say that. It's probably going to save a lot of money. I think my colleague Donna Cansfield said that there's the 20% cost of administration. For all these organizations, you have that 20% cost.

Ms. Joanne Young Evans: Minimum.

Mr. Mike Colle: So the question is—again, it's easy to say it—how is it ever going to be done?

Ms. Joanne Young Evans: Actually, we developed a model on the way it could be done in this LHIN, and in working with Community Support Services, we're only talking a \$30-million budget. But it is possible, and you put like services together.

I think that when we look at who is serving the resident, that front-line worker will never change. Hopefully, we'll increase the number, but that front-line worker will never change. The client doesn't need to know about the administrative piece. All they care about is that awesome person who is coming in to see them on a daily or weekly basis in order to offer services. Then what we need to do in the back end is amalgamate all of that back-office piece and save those dollars so we can do a much better job on the front line.

It's hard, because you have to take this hat off and be able to speak on behalf of your clients and not on behalf of your organization. That's the hard part, because people say, "Well, that's my job." But the people who work in this field are highly intelligent, highly motivated and they're very skilled. They'll be able to find a job somewhere else—if not in the health care system, then somewhere else.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. Thank you.

Ms. Joanne Young Evans: Thank you very much. I'm glad your system is now working.

The Chair (Mr. Ernie Hardeman): I just wanted to point out that you did make the sound come back on.

Ms. Joanne Young Evans: It's amazing, the power that women have.

The Chair (Mr. Ernie Hardeman): Thank you. And with that, before we have our next presenter, we do want

to take a short break so staff can deal with the sound system. We have to change from one to the other.

The committee recessed from 0837 to 0842.

The Chair (Mr. Ernie Hardeman): I call the meeting back to order.

She made the sound come back on and now I was able to do it on my own mike, but I can't do it on anyone else's. So we will persevere and see if it will come back on. Somebody suggested it may be the climate this morning.

UNIFOR ONTARIO HEALTHCARE COUNCIL

The Chair (Mr. Ernie Hardeman): Our next presenter is Shawn Rouse. He's representing Unifor. Shawn is from Oxford county. Welcome this morning, Shawn, to make your presentation. You have 15 minutes to make your presentation. You can use any or all of your time, as you see fit. I see your mike is on too. You can use all the time if you need, and if you don't, if it's less than four minutes, we will give it to one caucus, and I think that will be the official opposition. If there are more than four minutes, we will divide it equally to all three parties for questions and comments.

With that, the floor is yours for your presentation.

Mr. Shawn Rouse: Thank you very much for this opportunity to present today. I'd like to bring today a spotlight to a few issues involving health care delivery in Ontario through the local health systems act and its subsequent regulations.

My name is Shawn Rouse and I am the president of the Unifor Ontario Healthcare Council, which represents over 26,000 front-line health care workers across Ontario. I am a health care worker myself, with over 26 years in the hospital sector, previously as a dialysis assistant. Unifor is the largest private sector union in Canada, formed by the coming together of the CAW and CEP, representing over 300,000 members in every province and territory in Canada. We represent workers in more than 20 sectors of the economy.

I believe there are four main principles for the reform of LHINs. The core function of our public health system is to measure and meet the population's need for health care services. To date, capacity planning has not been done, even sectorally, in almost 20 years. Health system capacity planning must be done, and it should be based on an evidence-based assessment of population need. To date, LHINs have cut, closed, and facilitated or forced offloading of needed health care services, particularly hospital services, in regions all across Ontario. Health care planning has been divorced from population need.

The guiding principle of our public health care system is equality, or equity. This is not reflected in LHIN legislation, regulation, practices and decisions. Special attention is needed for access to publicly-funded care must be given to improve equity across all regions: in rural, remote and northern Ontario, for diverse groups, marginalized and at-risk populations, and aboriginal and First Nations populations.

Cuts forced under the LHIN system of accountability agreements and service integrations have transferred services from public and non-profit entities to private and for-profit entities—for example, physiotherapy, endoscopy, cataracts, colonoscopies, chronic care and long-term care. Many of these service transfers have been made without the required LHIN integration decisions. Though the legislation prohibits the minister from transferring services from non- to for-profits, it allows the LHINs to do so. Moreover, the legislation prohibits the forced mergers, closures and dissolutions of for-profits, but gives extraordinary powers to enable the minister to force amalgamations, closures and dissolutions of non-profits. Requirements that LHINs not transfer services to entities that charge user fees have been ignored and, when publicized, they're still ignored.

The public health system belongs in the democratic arena. This means meaningful public input, public involvement in the evaluation of decisions, access to documents and information, the right to appeal and representational governance. None of these exist in the LHINs.

Health care workers and their supporters have been raising the issue of minimum staffing levels to ensure adequate levels of care for every resident in long-term care. Staffing funded to an evidence-based minimum, measurable and enforceable standard in long-term care would go a long way to improve the lives of seniors in care.

0850

The current government is implementing changes to Ontario health care delivery through support of specialty outpatient clinics. The Ontario government intends to transfer surgeries, allegedly of a lower risk, from hospitals to smaller specialty clinics elsewhere.

Regulatory amendments have been made to categorize new and existing independent health facilities—IHFs—as health service providers, thus enabling the LHINs to fund and regulate. The Ministry of Health would pay facility fees to the clinics. It is totally unclear how much these subsidies would be, and whether these subsidies would be higher than regular OHIP payments.

I urge the NDP and Progressive Conservatives to study the challenges of this new health care venture, as the Ministry of Health has had an unimpressive record when transferring services to external agencies. Also, the process is in great haste.

I advise that IHFs not be used in this way, as a huge majority of these have been, in practice, for-profit clinics. We strongly recommend that any such specialty clinics, if desirable and necessary, be registered under the Public Hospitals Act and not as an IHF. The latter have been for-profit, very weakly regulated by the ministry, and would be transferred from hospitals that are not-for-profit, well-established, very closely regulated, and with emergency services on-site.

There are serious problems with the for-profit IHFs. These are not audited regularly, if at all, and have odd billing and record-keeping as a result of loose regula-

tions. Safety would not be ensured because of poor oversight, emergency services not on-site, and quality control protocols missing. There are higher costs because of the usual costs when restructuring, IHFs needing subsidies in addition to regular OHIP payments, new business and administration costs, and the need to find ways to collect fees.

The Canada Health Act covers hospitals and doctors with medically necessary services, so when services are transferred elsewhere, the CHA coverage must not be lost. The charging of fees which can limit access, guaranteed in the CHA, would be contrary to the Ontario Commitment to the Future of Medicare Act, 2004.

There would be a danger to the sustainability of community hospitals if hospital services are dismantled. Progressive Conservatives should be most concerned about the future of smaller, rural community hospitals.

The Ontario Auditor General's annual report in 2012 found that there were 825 IHFs, and 97% of these were for-profit, despite ministry claims otherwise. There were professional fees charged, and queue-jumping on ability to pay can occur. Most IHFs had not been tracked or audited, and these facilities will now do surgeries. For-profits will not do these surgeries unless profit can be made. Will it be user fees or extra subsidies? Regulatory conditions would have to be loosened. They would do the simplest, highest-volume surgeries, leaving the most costly and complex to the hospitals, with declining funding as a result.

If not-for-profits are established, will they remain that way? In the LHIN legislation, 2006, LHINs can transfer not-for-profits into for-profits but the inverse direction is not permitted. When services are provided in the community, there is less guarantee of patients not paying out-of-pocket, whereas in hospitals, the CHA guarantees against user fees. That would suggest that hospitals providing specialty clinics off-site could perhaps work.

I would like to end this submission with a quote from a presentation made by the Canadian Auto Workers to this very committee on February 8, 2006:

"Our fundamental position of criticism of this statute rests on the two following essential themes:

"(1) the absence of any meaningful public consultation or civic engagement, let alone a governance structure allowing for democratic and equitable representation of our diversity and communities; forums in which the people of Ontario as citizens are enabled and empowered to actively engage in the policy dialogue and policy choices concerning delivery of health services; and

"(2) the absence of any labour adjustment strategy to minimize the effects of this transformation agenda on health workers and the presence of specific arbitrary distinctions and discriminatory means by which the bill proposes to treat non-professional and 'non-clinical' workers—a significant attack on employment security without the protection of Bill 136 [PSLRTA, 1997]; a proposal to 'trump' existing negotiated contract provision restrictions in the event of work transferring to contractors.

"The challenge for our province in building an integrated and comprehensive public health care system capable of delivering safe, quality services and improved outcomes will be to ensure both a collaborative and focused effort by providers of health services and a deepening civic engagement by and accountability to the people of Ontario for their investment and commitment to medicare."

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about six minutes left, so we'll start with the third party. Ms. Armstrong?

Ms. Teresa J. Armstrong: Thank you very much, Shawn, for coming in and presenting to the committee. One of the things I heard you talk about was public engagement. You found that a very important example of how the health care system can be successful. Can you give me some examples where you think that we can engage the public better in order to make the health care system sector work better for patients?

Mr. Shawn Rouse: One way I can see is the engagement of allowing public participation in decisions of the LHINs. Currently, it's a rare occurrence—I'll use that term—that a meeting is actually publicized so that persons can have adequate time to be able to attend the meeting. Also, meetings are normally held during the daytime, and when they are made aware, persons who have to work for a living have no ability, usually on such short notice, to make the attempt to attend. They go out of their way to limit people's ability to attend or participate—even in writing, for that matter.

In the province of Ontario, there has only been, to my knowledge, one person from a labour group ever appointed to a board of a LHIN in Ontario.

The Chair (Mr. Ernie Hardeman): Thank you very much. The government: Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for coming today and for your presentation; I enjoyed your presentation. I have a couple of questions. On page 3, you identified that although the minister does not have the authority to transfer, the LHIN does, but that "service transfers have been made without the required LHIN integration decisions." What do you mean by that?

Mr. Shawn Rouse: Decisions are made by a board and just presented as, "This is what's going to happen." We've had cases that have been publicized in the newspapers where a decision has been made to transfer services away from a hospital—only to find the uproar or clamour by the local public to try to reverse a decision that has already been made.

Mrs. Donna H. Cansfield: Are you suggesting that there's no outreach to the community about the decision either before it's made or after it's made; that it's just made?

Mr. Shawn Rouse: Yes.

Mrs. Donna H. Cansfield: "Requirements that LHINs not transfer services to entities that charge user fees are being ignored"—can you give me an example?

Mr. Shawn Rouse: One that happens more times than most people would like think about is, if a patient has

been deemed to be capable of discharge from a hospital but has not yet found a place in a long-term-care facility which has been designated, a hospital has been known to notify the family or the patient that there are increased costs for staying, sometimes in the thousands of dollars per day. The minister has had to publicly be involved, in the newspaper, to ridicule that decision and have it reversed, only to find that the facility would do it again in a couple of weeks to another patient.

Mrs. Donna H. Cansfield: That's interesting.

Mr. Shawn Rouse: That's documented in the newspaper; that's not secret—

Mrs. Donna H. Cansfield: I think there is a provision, \$50 a day or something—

Mr. Shawn Rouse: It's a known fact that hospitals will present bills to patients, demanding thousands of dollars a day in overstay charges, to force patients to pick anything, to get out of the hospital, which is illegal.

Mrs. Donna H. Cansfield: Thank you very much.

The Chair (Mr. Ernie Hardeman): The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Good morning, Mr. Rouse, and thank you for your presentation. It's very illustrative of a lot of the issues outstanding with respect to the LHINs.

You did indicate at the beginning of your presentation that there were four main principles for reform of the LHINs, but you've got a lot of problems with LHINs. Do you think that they can be reformed, or do you think we need to look at a different structure?

Mr. Shawn Rouse: Well, I'm not a policy wonk, to say for sure; I'm a front-line hospital worker per se. The LHINs aren't, I believe, the best way to present what's happening. It's a way of isolating the government from decisions in health care. But as a funding agency, they do have their place. I believe that reform is possible, based on the issues of accountability and involvement of your communities in the decisions that affect those communities.

Mrs. Christine Elliott: You also indicated that we really need greater equity in the system; that there's too much discrepancy in service levels in different parts of the province. How do you think we could achieve that equity? Do you think it's a question of the ministry becoming more involved? Is it a question of the LHINs taking a stronger role in coordinating services? Where do you think we need to make the changes in order to achieve that equity?

Mr. Shawn Rouse: I believe there are probably a lot of people better versed to speak as to how to bring about the changes of equity, but one thing that comes to my mind quickly is that the drive to efficiencies has overwhelmed the needs of the population that the health care facilities are involved in. They will remove services that are needed in communities—rural communities or otherwise—in the name of efficiencies, completely disregarding the will or the need of that community to use that service. We've seen it in physiotherapy and we've seen it in maternity care, and the list just keeps going.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for making your presentation today, Shawn. When I introduced you, I didn't say that you were representing the Unifor Ontario Healthcare Council, so we want to make sure that's on the record.

Mr. Shawn Rouse: Thank you very much.

COMMUNITY SUPPORT CONNECTIONS— MEALS ON WHEELS AND MORE

The Chair (Mr. Ernie Hardeman): Our next presenter is Community Support Connections: Dale Howatt, executive director. Thank you very much for being here this morning. We look forward to your presentation.

Mr. Mike Colle: Mr. Chair, can you turn on the heat while we're here—or is that out of order?

The Chair (Mr. Ernie Hardeman): I don't run the facilities. Thank you.

Thank you very much for being here this morning, and I too feel the cold. I just want to assure you that the issue of the temperature in this room is not because you were here.

Ms. Dale Howatt: I certainly hope not.

The Chair (Mr. Ernie Hardeman): I do want to welcome you and tell you that you have 15 minutes to make your presentation. You can use any or all of that time to do that. If there's time left over, if it's less than four minutes, it will go to one party; if it's more than four minutes, we will divide it equally among the three caucuses for questions to your presentation. With that, again, thank you very much for being here, and we look forward to your presentation.

0900

Ms. Dale Howatt: Thank you very much for the opportunity to speak to you this morning. My name is Dale Howatt, and it is my privilege to present to you today on behalf of Community Support Connections—Meals on Wheels and More. We are a community support service funded by the Waterloo Wellington LHIN, as well as an active member of both the Waterloo Wellington Community Support Services Network and the Ontario Community Support Association, a network of agencies providing home and community care to over one million Ontarians every year.

Community support services form a very small but integral, responsive and growing part of the provincial health care budget. We serve a large number of some of our most vulnerable citizens, those who are living independently in their own homes and those who are struggling to do so. As I present to you today, our organization alone is supporting 4,594 seniors and adults with disabilities in our community: 447 are over the age of 90, living independently in their own homes; and 16 are over the age of 100, living independently in their own homes.

Community Support Connections—Meals on Wheels and More provides a myriad of volunteer-driven supports and services that enable these people to live with independence and dignity, services such as Meals on

Wheels, escorted rides to and from doctor's appointments and the grocery store, gentle exercise, friendly visiting and much, much more. Last year, 600 local volunteers contributed more than 70,000 hours to direct service delivery. That's the equivalent of approximately 42 full-time jobs in our world, and at that time, we employed fewer than 23 full-time staff.

We like to think of our organization as an integration success story. On May 2, 2008, four small community support service organizations officially merged to become Community Support Connections—Meals on Wheels and More. In the subsequent five-year period, we realized a significantly increased capacity to serve by leveraging that resulting change into a client-focused, innovation-embracing culture, and by redirecting redundant administrative resources to direct service.

Merger is an increasingly common phenomenon in our world. But we're now coming up to our sixth birthday and so are able to provide information about real results in the lives of real people here in this community, results that have continued over time, results that are sustainable. During the five-year period of time between our merger and the end of this last fiscal year, the number of clients we served increased 39%; the number of rides we provided, 118%; the number of sites where our services are available to individuals in the community, 338%; and community dining and exercise units, 630%—all within a relatively stable funding context of 16% over the same period of time. That's a lot of numbers, but the resulting differentials range between 23% and 614%. That's capacity.

This capacity to serve was released from four structures that previously existed. This capacity to serve is critical as we seek to meet the needs of our aging population with very limited resources. This capacity to serve is critical as we examine the sustainability of our health care system and seek ways to improve it.

As a larger organization offering more services than its predecessors, Community Support Connections—Meals on Wheels and More is also better able to understand and meet the increasingly complex needs of the people that we serve: 46% of our clients receive more than one service. That means that with the old structures, close to 2,000 local seniors and adults with disabilities would have had to tell their story at least two times and maybe three times in order to receive the services that they now receive with a single phone call. Some may not even have been receiving the services that they need because they didn't know to ask or because the organization offering a single service was unaware of their other needs.

This year, with the support of the Waterloo Wellington LHIN, we're growing even faster. In April, we incorporated another local stand-alone CSS program into our offerings, further simplifying access for local residents. Strategic, targeted investments will also enable us to leverage community goodwill and innovative thinking to deliver more services to more seniors and adults with disabilities in our community.

Our message, however, is not about our organization. It's about capacity, collaboration, system thinking and integration. It's about putting the client at the centre of care. We know that integrated health systems provide better outcomes. Integrated health services do likewise, and can sometimes yield enhanced capacity in the magnitude that I've just mentioned.

In addition to structural integration, we've participated in other integration activities focused on putting the client at the centre of care. Our network developed a process called Easy Coordinated Access, a way of simplifying access to the many programs and services that comprise our sector. This process is now being replicated across disciplines and in other jurisdictions.

With the LHIN's encouragement, our local network also utilized the introduction of a provincial common assessment tool to develop a community team of assessors rather than an organization-by-organization set of assessors and processes. Communication is now simplified. Service is now simplified. Duplication has been minimized.

Recent discussions have touched on the possibility of shared care coordination between community support services and CCAC. Imagine the improved client service possibilities. We've developed shared front-door and home-visit protocols with partner organizations to ensure that the often-used phrase "every door is the right door" is in fact a reality for the people we serve.

These are all examples of integration initiatives that are moving our system forward. They are improvements that put the client at the centre of care. This happens most effectively at the local level. Is there more work to do? Without a doubt.

A progressive, modern health care system keeps people healthy and connected in their homes and communities, not sick and alone in institutions. Home and community support works because it offers local, flexible, community-based solutions with and around the people we serve. We know that keeping people living independently in the community and out of hospital is a more cost-effective means of health care delivery. Investing in home and community care frees up hospital beds. It unclogs emergency wait rooms and decreases long-term-care placements and long-stay hospitalizations, all at a lower cost to the health care system.

Effective transition of services to the community, however, requires transitioning resources as well. To meet current and future need, we must ensure that there is sufficient funding and sufficient funding flexibility afforded to community agencies in order to attract and retain qualified workers; in order to appropriately recruit, screen, train and support those volunteers whose time, expertise and considerable goodwill tell our most vulnerable citizens that people do still care; to continuously improve quality and manage risk well; and to actively participate in system solutions.

As we continue to transition care from hospital to community, we need an understanding of community capacity and community resiliency. This is an understanding that comes best at the local level. As we invest

taxpayer dollars in home and community care, we need an understanding of where we get the greatest return on our investment, an understanding that, again, comes best at the local level.

In our current state, Community Support Connections—Meals on Wheels and More and other community support services are active participants at every health links table. We're also active participants at many other system tables, contributing to cross-sectoral system solutions. This was not always the case. It is a result of local system management and is critical to ensuring that community support services are fully utilized and leveraged to meet system goals.

There are many challenges ahead of us. LHSIA provides the framework within which we've begun the journey. Now is the time to build on momentum, to fully leverage the existing legislation, to build upon existing strengths, relationships and opportunities, and to push the integration agenda forward so that we can continue to find new ways to release capacity that already exists in our system and meet the needs of our community as it grows and changes. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have two minutes for each caucus. This time, it starts with the government. Ms. Jacek?

0910

Ms. Helena Jacek: Thank you, Ms. Howatt, for coming. Looking at this very useful description of services that we were provided with by Joanne Young Evans, I certainly see Community Support Connections in a number of areas, both in terms of service provision and geographic areas, but I do notice that, apparently, you're not involved in Guelph-Wellington and north and west South Grey.

Given your track record of successful mergers and, obviously, all of the positive things that you've been able to do over the last few years, are you looking to be able to service the whole LHIN in the future, to ensure some consistency for residents and so on?

Ms. Dale Howatt: We're looking to ensure that every resident has equitable access to service. Sometimes that comes through structural integration through merger, and sometimes it comes through active and proactive partnerships. Right now, we are currently actively working with our partners in Guelph-Wellington to ensure that the service offerings are indeed equitable across the system. I think there are many ways of getting there.

Ms. Helena Jacek: What role does the LHIN play in that? I mean, it sounds like you, as an organization, are very conscious of these needs, but would this not be happening if we perhaps didn't even have a LHIN?

Ms. Dale Howatt: I'm not so sure that it would. Moving the system is very difficult. Implementing change is very difficult.

I'll give you a very recent, concrete example. One of the investments of new funds that I alluded to in my presentation was to provide gentle exercise and falls prevention classes across the Waterloo Wellington LHIN.

We did so in active partnership with VON Canada, to ensure that those services were equitably offered across the region, and that was a condition of the funding. In our case it was not necessary, but I think it's important that it be a condition of the funding.

The Chair (Mr. Ernie Hardeman): Okay. The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you, Ms. Howatt, for a great presentation, and for the great work that you're doing in building capacity significantly while still keeping the client at the centre of all of your plans.

I'm just wondering if you would be able to point us in the direction of any material that you might have about how you were able to do this, and the process that you went through. I think that would be really helpful for us as a committee as we consider options going forward. I was also wondering if we could get a copy of your written presentation from today, if you'd be kind enough to share that with us.

Ms. Dale Howatt: Absolutely. I'm happy to forward that. I was trying to save a tree or two. All of the information about our merger is publicly available on our website, and I will forward that link as well. Our most recent annual report speaks to the capacity numbers—all of those percentages that I reeled off for you. There's quite a visual graph in our most recent annual report documenting that.

Mrs. Christine Elliott: Thank you. That would be very helpful.

Ms. Dale Howatt: You're most welcome.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Fife?

Ms. Catherine Fife: Thank you very much, Ms. Howatt, for the presentation. Just to sort of piggyback on Ms. Jacek's question around the role of the LHIN in the four agencies coming together: Did the LHIN inspire, at least, the sitting down and having a conversation, the facilitation of the agencies coming together for a more coordinated approach? I'd like to pick up on that a little bit more.

Ms. Dale Howatt: The LHIN was very supportive of our merger. It did happen in the very early days of the LHIN itself. The legislation was 2006; our organizations began discussing a potential merger in 2007. I think that the environment created by LHSIA actually encouraged health service providers to think differently about how we're constructed and how we deliver services, and that, in fact, was an impetus to the merger.

Ms. Catherine Fife: Okay. That is good for us to know. The other issue: Home care, of course, was in the last budget, so there is some new funding flowing out to the province; it's long overdue. But there is a conversation afoot about minimum levels of care for home care. I know I've heard from personal support workers, in particular, who feel that they would like to spend more quality time, because home care on the surface sounds great, but it also is tied to quality. Can you comment on that at all? Because it is a human resources issue, and it is a funding issue.

Ms. Dale Howatt: I think that ensuring quality in everything that we do is an important aspect. You'll notice that in my presentation, I talked about capacity, not efficiency, because I think that effectiveness is an important metric. As we look at community care, we need to ensure that the interventions that we're offering are not only efficient but effective.

We see that every day with very simple supports in terms of volunteer interaction. Sometimes, for some of our more well clients, it's as simple as a daily social contact.

Ms. Catherine Fife: Absolutely.

Ms. Dale Howatt: So, ensuring that people get the right services at the right time needs to be an element of every individualized care plan.

Ms. Catherine Fife: Okay, and just one quick final—we've heard on the finance committee that not-for-profits across the province would like to see some greater support, because, as you pointed out, 600 volunteer hours equals 42 FTE. Is there a role, or can you comment how government policy could be more supportive of the not-for-profits within the health care model?

Ms. Dale Howatt: I think it's important that policy-makers understand that there is a cost associated with leveraging volunteer resources in the community and doing that well, particularly with vulnerable populations. Sometimes not-for-profit organizations are challenged by what looks like administrative costs in coordinating the efforts of all of those volunteers.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. We thank you very much for your presentation. Sorry for the climate.

Ms. Dale Howatt: Not a problem. Thank you.

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is the Waterloo Wellington Local Health Integration Network: Joan Fisk, chair, and Bruce Lauckner, chief executive officer. Welcome.

Thank you very much for being here this morning. As with previous presenters, you'll have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's time left over, less than four minutes, it will go to the opposition caucus. If it's more than four minutes, it will be divided equally among all three. With that, thank you very much, again, for being here. The floor is yours.

Ms. Joan Fisk: Thank you very much as well. Good morning. My name is Joan Fisk and I'm the chair of the board for the Waterloo Wellington LHIN. I want to start by thanking the standing committee for taking the time to visit Kitchener today. The work you're doing is critical, and we welcome the opportunity to appear before you in our own community.

I also want to explain the format of our presentation. I'll speak for a couple of minutes, and then I'll pass the

microphone to our chief executive officer, Bruce Lauckner, who'll speak for roughly 10. We appreciate that the committee may want to ask questions, so we've saved some time at the end for that.

I became chair of the Waterloo Wellington LHIN almost three years ago. My background is primarily in business at the CEO level. I have extensive governance and community service experience. I've served on boards of two different post-secondary institutions, and I'm currently on the board of an insurance company and a public-private partnership. I'm also a member of various advisory groups, and I volunteer extensively.

I believe deeply in the challenging work we're doing at the Waterloo Wellington LHIN, and I feel that the model of local, community-based boards is crucial. Because we live here, we have first-hand knowledge of the system. We hear about our residents' experiences regularly through the course of our everyday lives, and through our activities in the broader community, we also hear. We have a personal stake in ensuring the decisions we make are the best possible ones; they will affect us directly.

Openness and interaction with the community is also fundamental. We hold our board meetings approximately once a month, and at each meeting we welcome at least 50, and often more than 100, visitors. Our approach at the meeting is intended to both inform the broader audience and ensure the board is able to make good decisions.

We receive regular feedback about the health system when we're in conversation with community members who attend our meetings. After the meetings, we frequently reach out to them, or they reach out to us, to continue the interaction.

We see health service provider board-to-board and governor-to-governor engagement as a key aspect of our role. For this reason, we host meetings and events that bring people from different boards together so they can learn from one another, better understand their role within the system and provide ongoing input to the LHIN.

I suspect you've listened to presentations over the past week and heard a wide range of views of whether or not the LHINs are effective, whether targets are being reached, whether there's enough local input into decisions, whether the LHINs should have more authority or less, and much more.

Some comments we'd agree with; others we likely would not. But we're not here today to respond to what others have said, and we're not here today to tell you everything is perfect. We believe great progress has been made within Waterloo Wellington, and the information Bruce is about to share will illustrate that. However, there is still much to do.

Over to you, Bruce.

Mr. Bruce Lauckner: For the record, my name is Bruce Lauckner. Thank you, Joan, and thank you, committee members, for your commitment to this sector and this important task.

0920

As I've read the Hansard transcripts from the hearings to date, I've been impressed with the questions being

asked and the depth of the discussion. Your knowledge of the system comes through very clearly, as does your strong commitment to your constituents and the well-being of the people of Ontario.

In terms of my background, I've been at the Waterloo Wellington LHIN for just over eight years, and in the role of CEO since 2010. Prior to that, I led high-performance teams in the public and private sectors, including at Sun Life Financial, Clarica, KPMG and in municipal government. I've been involved in or led major changes, mergers or amalgamations for over 100 organizations.

Recognizing that you've already received the LHINs' four recommendations about the legislation, my plan today is to focus on our local story: our performance and the importance of the local model in achieving results.

When the topic of LHIN performance is raised, the focus is usually on targets. Currently on the Waterloo Wellington LHIN website, there are two charts that we call dashboards. These deal with local areas for improvement, which are tied directly to the objectives in our Integrated Health Services Plan and our annual business plan commitments. They reflect the targets that our hospitals and other health service providers have agreed to meet.

One dashboard gives a monthly snapshot; the other focuses on the change from the time the factor was first measured. If you look at the monthly snapshot version, you'll see a number of factors that are labelled green, yellow or red. These show you where things stand at a particular moment in time. They don't tell you what happened the month before or what will happen the following month. And for any number of health-care- and non-health-care-related reasons, some of these indicators can change from red to green, or vice versa, in the space of a single day, let alone a single month. So the month-to-month indicators tell only part of the performance story.

We pay close attention to this dashboard to ensure our health service providers are on track to achieve the necessary system improvement for our residents. But we don't just check off a box when we see green and say, "Great; that's done." Our core value at the Waterloo Wellington LHIN is to act always in the best interest of our residents' health and well-being. The first question we therefore ask is whether or not the improvement is sustainable. If the answer is no, we work with the appropriate health service provider to figure out how to make it so. If the answer is yes, our next step is to look at the target and ask if we, as a system, can do even better.

Another part of the performance story is told by the second dashboard, and that looks at trends. This is particularly helpful because it shows the kind of progress that has occurred in the system since our LHIN came into existence.

In terms of measuring impact, it's crucial to look at the overall changes over time, to really see what's happening and where significant work still needs to be done to improve the health care available to our residents. In Waterloo Wellington, there have been a number of substantial improvements.

When the LHINs were created, this region had some of the longest wait times for non-urgent CT and MRI exams, for cataract surgeries and for hip replacements. These wait times have decreased substantially.

But the performance of the system is not just about wait times; it's about quality of care. As an example, when the LHINs started, there was limited local access to quality care in a number of areas in this region, such as cancer and cardiac. Many people had to drive out of this area for treatment. Now, in addition to the improved wait times, this region has one of the best overall cancer programs in the province and arguably one of the best cardiac centres in the entire country.

When the LHINs started, there was insufficient physician coverage in several of our local emergency departments. Now we have a full complement, and the departments are functioning much better.

Let me give you just a few examples from the trend dashboard that I mentioned a few minutes ago. The percentages that follow show the improvement from that starting point, which is either when the LHINs started or when the factor was first measured:

- improvement in emergency department stay for admitted patients: 49.7%;

- improvement in wait times for non-urgent MRIs: over 73%;

- for non-urgent CT scans, the improvement is over 80%;

- for hip replacements, the improvement is almost 65%; and

- for cardiac bypass surgery, it's almost 80%.

And now tens of thousands more residents in our region have a primary care provider that they didn't have access to before.

Percentages are helpful in giving an overview, but I said before that it's not just about the stats. Let's take it to the patient level and look at a personal example. Think, for instance, of a woman in her late 50s or 60s who's waiting for a knee replacement. In 2005 in this LHIN, she would have waited for roughly 15 months. Now, for two of our three hospitals, the wait times are closer to three months and five months, respectively. So we're looking at as many as 12 pain-free months for that same woman today, compared to the way it was before the LHINs were created. I know this matters, because I've talked to many people who have had hip and knee replacements. I've shadowed therapists on home visits, and I've had people tell me how much of a difference this surgery has made to their lives.

Before I talk about the importance of the local model, I'll briefly explain why it's also necessary to consider how targets are set when assessing performance. Let's look at the factor that measures the amount of time patients spend in the emergency department before getting admitted to hospital. These are the most complex patients and they often need diagnostic tests and assessments.

The average length of stay for patients in this category in Ontario is approximately 27 hours. Rather than setting

the target in Waterloo Wellington at something like 20 hours, which would still be a significant improvement over our starting point of 29, we set the target at eight hours. The average length of stay in Waterloo Wellington, through the collaboration of the LHIN and our local providers and the good efforts of our front-line staff, is now 14.6 hours. That's the lowest quarterly level ever recorded in Ontario history since we started measuring wait times in 2008.

Despite the fact, though, that there's almost a 50% improvement since the starting point, and we're number one in the province, this metric isn't green on our dashboard. That's because we don't set targets based on how easy they are to achieve; we set targets based on the lowest of the evidence-based clinical practice or the provincial average. In Waterloo Wellington, we believe this approach is in the best interests of our residents. It's simply the right thing to do.

The results I've shared over the past few minutes demonstrate just some of the improvements in this region's health care since the LHINs were created.

0930

Next I want to address the LHINs' role in this improvement and why a local presence is so important.

The provincial government operates, if you will, at a 30,000- or 40,000-foot level and sets the very important overarching vision for health care. Our health service providers focus on and are experts in their particular areas. They have a strong understanding of their patients' needs when they walk through the door. They work at what can best be described as the street level. Ideally positioned between these two levels, the LHINs have a regional system view. We think about how patients move through and across the system, and what they experience while doing so.

A concrete example of how this locally based, system-level approach has improved the patient experience is a program we call Easy Coordinated Access. The LHIN had more than 33 community support services across more than 24 different agencies. Residents found it difficult to access the best services and providers based on their particular needs; multiple phone calls or visits were required. Also, service levels and wait times were uneven, and primary care providers and agencies struggled with referrals. The experience was very frustrating for our residents. I know this because our residents told me so. They'd talk to me about having to call one agency for transportation, another for adult day programs and yet another for a home visit.

LHIN staff worked with health service providers to design the Easy Coordinated Access program, which was introduced to make it easier for individuals to access these kinds of community support services. Using a new web-based search and mapping tool, it centralizes intake through the community care access centre and it ensures a coordinated approach that dramatically changes the experience of the resident.

As the example I've just given illustrates, having LHIN staff focus on the system from a local vantage

point is key to improving the patient and resident experience. But why is that the case? It's because we're local. Because we're local, the medical and business professionals who work at the LHIN interact with our health service providers on a personal and professional level. We bring together providers who would likely not connect otherwise, and we can do this effectively because we know them and we work with them regularly.

Because we're local, we can readily support providers as they collaborate to make improvements each and every day. When necessary, we intervene to ensure the decisions that are made are in the best interests of the residents. We lead the creation of programs that increase quality and ensure consistent levels of care across the system.

Because we're local, we're immersed in the very environment we're trying to improve, and we understand and share the needs of our residents. We interact regularly with our residents who contact our office, and we formally engage our communities, as the legislation requires.

Our LHIN physician leads and our staff—they've been nurses, physiotherapists and so on—work or have worked on the front line as well as in our system. In fact, our physician leads work with us and with their patients on the same day. In this way, we hear about needs—what needs to be done now, what needs to be done in the future—and we make investments and funding decisions based on their input.

Before I close, I'd like to provide one final example of the current model in action. It's about achieving best practice. It's about the patient experience.

Because we're focused not just on what's happening at one individual organization but at all our health service providers, the LHIN recently made the decision to change the system of stroke care so we can meet best practice for all the residents in our region. As a result of this action, every year from now on, 20 more Waterloo Wellington residents will survive their initial stroke. Every year from now on, 65 fewer people in this area will die or experience serious debilitation from stroke; and every year from now on, between 40 and 105 more patients will return home rather than go into long-term care.

Are there more challenges like stroke? Yes. Is Ontario's vision for health care achievable? Yes. Do the LHINs play a necessary role in the system that's distinct from the roles that our health service providers play in realizing that vision? Most certainly. The results speak for themselves.

When the LHIN was created, hospitals and other health service providers in our region were running deficits. Our local hospitals are now working with balanced budgets. Despite the fact that we've held the line on smaller increases for several years so we could increase home care services and expand primary care, hospitals in this region are generating slight surpluses, and that has been used for things like the purchase of new equipment.

Quality has also improved, and volumes of service for many hospital and community sector organizations have increased. We are increasingly shifting the focus of the system to health promotion, primary care interventions and better management of chronic disease.

The improvements I've talked about this morning tell a story of a sector that's realizing a health care vision because of the work that's done at the system level by the LHINs and at the front-line level by our health service providers—everyone working locally together.

The strength of the current legislation is that it recognizes the importance of local, so that the patient is at the forefront. Government can focus on the overall vision for health care in the province; health service providers can focus on the individual patients; and the LHINs right across the province can focus on the regional system and the patients' journey through it, while sharing their learnings and best practices with each other. Each role is vitally important, and we're deeply committed to the part we play.

Thank you, again, for the opportunity to present today and for your work on behalf of Ontarians.

Joan and I would be happy to take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, but the time has expired—15 minutes and 15 seconds. Thank you very much for your presentation. It is very much appreciated and was very well done.

GRAND RIVER HOSPITAL

ST. MARY'S GENERAL HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presenter is from Grand River and St. Mary's hospitals: Jordan Golubov. Thank you very much for being here this morning. As with all presenters, you will have 15 minutes, and you can use any or all of that time to make your presentation. If there's less than four minutes left, we will have questions from just one caucus; if there's more than four minutes, we will split it evenly with the others. With that, the floor is yours.

Dr. Jordan Golubov: Good morning. My name is Dr. Jordan Golubov. I'm the head of gastroenterology for Grand River Hospital and St. Mary's General Hospital. Thank you for allowing me to speak at this forum. I'm speaking on behalf of the eight gastroenterologists who care for patients in this community. I've been practising here for over 20 years.

Our LHIN has thus far not played a substantive role in shaping the delivery of gastroenterology and endoscopy services. This will change as the LHIN takes on an important responsibility in determining the role of privately administered and operated endoscopy clinics in our region. This could have a profound effect on the nature and quality of our gastroenterology and endoscopy services.

The eight gastroenterologists who work exclusively at these two hospitals have significant concerns about the Ministry of Health and Long-Term Care plan with regard

to these private clinics. The ministry proposal could result in a substantial shift in these procedures from our public hospitals into these private facilities.

I am a member of what is the largest gastroenterology specialty group in the Waterloo Wellington LHIN. We're the only service that provides 24/7 gastroenterology call in this LHIN. Our two hospitals have the LHIN's best-equipped endoscopy units. There has been tremendous community support for our new endoscopy units, as evidenced in particular by the donor plaque outside of the St. Mary's General Hospital unit.

We have a highly skilled pool of dedicated endoscopy nurses. They are required to optimize patient outcomes, whether for the so-called routine procedure or the complex intensive care unit patient.

We provide a comprehensive and integrated model of care for community members, whether they are inpatients or outpatients. This comprehensive care model includes our pathology, radiology and general surgery departments, as well as our centralized and integrated Waterloo Wellington regional cancer program. Our working environment fosters the development of advanced endoscopic skills, which benefit the entire community. We always strive to provide the highest quality of care. We have a culture of stewardship of our health care system's limited resources.

The action plan for health care by the Ministry of Health proposes community-based so-called specialty clinics for so-called high-volume, routine procedures, such as colonoscopy, in order to offer patients access to high-quality care at less cost. The Ministry of Health states, "We will not compromise on quality, oversight or accountability." Our LHIN will be a key player and key part in this decision-making process in conjunction with our hospitals.

I can unequivocally state that there is no so-called "specialty clinic" or endoscopy unit in our LHIN that has more well-trained gastroenterologists or better equipment than what we have right now at Grand River and St. Mary's General Hospitals. Our procedures are performed in a highly regulated and monitored environment to perform procedures safely and effectively. A true specialty clinic first requires the cognitive ability to assess whether or not a patient needs a procedure and, if so, what kind of procedure; how to interpret the findings of that procedure; and then to make appropriate follow-up and patient management decisions. The largest true specialty clinics in our LHIN are already to be found at Grand River and St. Mary's General Hospital.

In contrast, these out-of-hospital clinics are really privately operated procedure centres that frequently do not provide the aforementioned comprehensive model of care. These private clinics need to perform procedures in order to generate revenue. This will bias these private clinics towards performing procedures. This is not an environment that is supportive of stewardship of health care system resources but rather one of utilization. Studies have shown that 10% to over 30% of endoscopic procedures may be performed unnecessarily. I think that a retrospective audit comparing procedure indications at

private clinics versus hospitals would be very instructive to identify where the most unnecessary tests are done based on current standards of care. We may find that the cost benefit of a possible lower procedure cost in a private clinic is overwhelmed by the cost of the unnecessary tests that are fostered by this utilization-driven environment.

Is the cost of the procedure truly cheaper in these private clinics? Many private facilities and some hospitals employ anaesthetists in their endoscopy units. They are very costly to the taxpayer. Their fees are multiples higher than the cost of the hospital registered nurse that they replace. They're unnecessary to the performance of endoscopy. The Ministry of Health currently is not choosing to measure this cost to the taxpayer in their endoscopy cost calculation. This is a negative bias against the cost of our endoscopy units, which do not employ this form of costly endoscopic care. Is this fair?

0940

Private clinics also avoid doing any procedure that incurs equipment costs that will reduce profit margins. The procedures are repeated at the hospital, leading to higher equipment costs for the hospital and further OHIP billings for repeat procedures and more patient risk. As clinics do not provide a comprehensive model of care, repeat consultations may be required, adding additional costs to the taxpayer. In the end, if the Ministry of Health does not look at the total cost of care, it will produce a flawed conclusion.

What about patient outcomes? During colonoscopies, it's vital that adequate time is spent visualizing the patient's colon in order not to miss growths that are or could become cancerous. However, the Cancer Care Ontario Guideline for Colonoscopy Quality Assurance in Ontario states that no minimum time needs to be spent inspecting the colon for quality assurance purposes as this would have a negative impact on productivity and efficiency, for negligible gain. This is in contrast to Canadian, American, European and UK guidelines. So here we see that in the name of efficiency, which is a very popular term, colonoscopies can be completed without a minimum inspection time. This fits with the Ministry of Health price-per-volume reimbursement model and rewards physicians financially. However, as a patient, I would not want the time inspecting my colon, which may not be repeated for 10 years, reduced in the name of efficiency. I would want my physician to spend as long as was necessary to inspect every nook and cranny of my colon so that I was protected from developing colorectal cancer to the greatest possible extent. The focus for the taxpayer and for patients should be quality, not quantity of care. It is better to do procedures less often and to do them as well as is possible to maximize benefit and minimize risk.

The Ministry of Health reimbursement model may also create a conflict of interest. What is good for the physician financially may not be good for the patient clinically.

In terms of outcomes, we do have a study published from this province, which I have referenced for you in

the handout. It looked at patients who were diagnosed with colon cancer here in this province between 2000 and 2005. This study suggested that a patient who had had a colonoscopy performed at a private clinic had a 1.7 times greater risk of developing colon cancer over the next three and a half years, compared to if they had had it done in hospital. We should have more information from Ontario about the performance of these privately-run facilities before we decide to move more procedures to them. My colleagues and I feel that the Ministry of Health's price-times-volume model is not supportive of optimal patient outcomes.

Any shift of endoscopy services from the Grand River and St. Mary's hospital endoscopy units to private clinics will not enhance the current quality of GI care that patients receive in this area. We believe it will be diminished. We believe that the operating characteristics of private clinics require compromises to be made as a result of the Ministry of Health's reimbursement model. These compromises are not made in our hospital environment.

Now let me tell you about one of the most dire consequences of moving care out of hospital to private clinics. If the majority of GI practice is moved out of hospital by the proposal of the Minister of Health and the Ministry of Health, there may be a loss of gastroenterology service to the hospitals. Many physicians increasingly value a less-demanding professional lifestyle. This potential shift of endoscopy to these private clinics will allow gastroenterologists to practise without the use of hospital resources. One will no longer have to worry about being awakened at 2 in the morning to see a gastrointestinal hemorrhage in the intensive care unit. We have seen other specialties such as plastic surgery walk away from our hospitals, resulting in on-call coverage difficulties. It will be a setback.

The issue with gastroenterology is that one needs a highly skilled and experienced group doing hospital work frequently enough in order to maintain their skill and judgment. A private clinic physician who does irregular hospital work would not be able to offer the same clinical and endoscopic expertise. This could compromise patient outcomes. GI care requires a pool of highly skilled on-call endoscopy nursing staff. Will we have enough to cover both hospitals if our endoscopy units are downsized?

Lastly, the hospital environment is an intellectually and technically dynamic environment that is the product of a varied and large patient population and the interaction between a large number of gastroenterologists, endoscopy nurses, pathologists, radiologists and surgeons. It is this hospital endoscopy environment that has advanced patient care for residents of our region. Moving much of hospital-based endoscopy to off-site private clinics would substantially weaken the heart and soul of the region's gastroenterology care.

It's all too easy for our Minister of Health to stand in front of a private eye clinic in Toronto and state how wonderful private clinics are. I would ask her to come to Waterloo region to see the outstanding endoscopy units

at Grand River and St. Mary's, so that she has a better understanding of the model of comprehensive care that we provide to community members. Though she'll have to pay for parking to visit them, she'll find that our units are focused on optimizing patient outcomes and that we value quality of care above quantity of care. Is that not what she would want for herself?

Our LHIN should maintain the current level of high-quality endoscopy services at Grand River and St. Mary's General Hospital. Our community and hospitals depend on them. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just four minutes left, so the official opposition has the questions.

Mrs. Christine Elliott: Good morning, Dr. Golubov. Thank you very much for coming to present to the committee this morning.

You've raised some significant concerns with respect to endoscopy procedures and where they should be located. For the purposes of this committee, it would be helpful to know if you've raised these concerns through your LHIN to get to the Ministry of Health. How have you approached it? Has it only been directly with the ministry? What role, if any, has your local LHIN played?

Dr. Jordan Golubov: Well, it's a new process. I've met with the CEO. Both hospitals are very concerned about what could happen to GI call. They've had real issues in the past.

We're actually a pretty critical service. If you look back 20 years at the kind of care people were getting, it was not very good. So, the community here sort of doesn't—you know, I think they can appreciate now what we do. But if you look at the potential for fragmentation and piecemeal care—this is the first forum in which I have presented it publicly, but we have met with our chief of staff and CEO of Grand River.

Mrs. Christine Elliott: At this point, you haven't had any contact with the LHIN to advance the cause?

Dr. Jordan Golubov: No.

Mrs. Christine Elliott: That might be helpful. I would suggest—

Dr. Jordan Golubov: Yes, we will. They're very well aware of what this means.

Mrs. Christine Elliott: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated, and we look forward—

Ms. Catherine Fife: Is there any time left?

The Chair (Mr. Ernie Hardeman): No. There was less than four to start with, so there was only one questioner.

Thank you very much for your presentation. We very much appreciate it.

REGION OF WATERLOO

The Chair (Mr. Ernie Hardeman): Our next presenter is the region of Waterloo: Chair Ken Seiling. Mr. Seiling, welcome.

Thank you very much for being here, Ken. As with other delegations, you have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you don't, if you leave more than four minutes, we will divide that time equally among the three caucuses. If you leave four minutes or less, it will go to one caucus. The floor is yours.

Mr. Ken Seiling: I propose to be very short so you can catch up on your scheduling. You don't need to use all the time, because I just have two or three points that I want to make in the presentation.

As you know, I'm the chair of Waterloo region. We've had significant contact with the LHIN over the years, whether it be through our public health unit, through social services, the CMSM for housing, long-term care, Sunnyside Home—a whole range of things. So we have ongoing contact with the LHIN and quite a bit of experience with it.

I just want to come today to speak very briefly to the topic of LHINs. There has obviously been a lot of discussion on whether LHINs should exist or not exist, whether they should be changed, and uncertainty around the future of the LHINs. I just wanted to come here to express and voice my support for the continuance of the LHINs as a planning tool and a functioning tool within the municipality and around us here.

I really do not like the idea of moving back to a centralized, bureaucratic approach to the provision of health care within the communities, setting things up in Toronto. When they first started up, there were some questions about start-up and how they operate, but I think the last few years have seen quite a bit of success here. I would say that in our own LHIN, the last two or three years have been a model—quite a bit of success. That's not to say that some fine-tuning can't take place, but I just want to be here to voice my support for their continuance because I think their closeness to and their knowledge of the local scene allows them to do a lot of rational planning for the system that reflects local needs and local interests. I would hate to lose that. I think that has been very successful here.

It has been very successful on a number of fronts. One of the examples here I'll give is the work done on seniors and keeping people in their homes, providing care for seniors. The coordination of that work for the last two or three years has been exceptional here. We're seeing a great deal of that, working with grassroots organizations.

One of the things the LHINs have the ability to do is to have knowledge of what happens at the grassroots in communities and an ability to work with organizations and grassroots organizations to build a better system for people locally that responds to people locally. My concern is that if we take that away from the local planning function, we'll lose that ability to work with grassroots.

One of the models we've had here, particularly in this region—a long history, particularly in social services but also in the health field—has been the success of the grassroots delivery of services or a consolidation of some of those to provide better services. I think the LHIN has

done quite a good job of pulling some of those things together. You heard some of that earlier. When I walked in, I think I was hearing some evidence of what has been going on in that particular field. I would hate to see the loss of that.

I think centralized planning would see a cookie-cutter approach that's not reflective of what goes in local communities, so I would say that has been a success.

One of the issues that we have identified is that we think that the whole question of the determinants of health needs to be broadened within the scope of the LHIN and the ability of the LHIN to work within areas, because the determinants of health are not just simply medical determinants. They're issues of poverty; they're issues of housing, supportive housing, employment, community supports—all those sorts of things. Sometimes there's a role for the LHINs to be more active in trying to pull some of those things together.

A good example of that is the whole question of supportive housing. I don't think there's a community in Ontario that doesn't have a dearth of supportive housing. That's a major issue. Yet trying to pull together those projects has been problematic over the years because we have the Ministry of Health doing part of the funding; we have the Ministry of Community and Social Services doing some funding; we have the Ministry of Municipal Affairs and Housing doing some funding; and then community groups trying to pull us all together. Somehow there needs to be some mechanism to pull some of this together—and whether there's a better role for the LHINs in helping to coordinate and breaking down some of those provincial silos that get in the way of building some of this housing.

You might want to turn your minds to how the provincial silos could be weakened somewhat through the provincial framework here. I just raise that as an example of where I think—if you're looking at legislation and what the legislation allows the LHINs to do and not to do, and other ministries—you might want to turn your minds to doing that.

I think that covers off a lot of what I wanted to say. I just wanted to come here and speak generally in support of the concept of the LHINs and their importance to community and community-based planning for health care, and say that I hope that whatever you do strengthens their role and not weakens it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about 11 minutes left.

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Mr. Ken Seiling: You don't need to use it. You can pass it and catch up.

The Chair (Mr. Ernie Hardeman): It starts with the official opposition.

Mrs. Christine Elliott: Thank you very much for your presentation and your comments today. We have heard from other groups—I think the RNAO also recommended that we have some way of bringing in the determinants of health, more broadly speaking. Have you

thought a little bit more about exactly how that could be brought in, and what kind of a role the LHINs could play in coordinating that for each community?

Mr. Ken Seiling: Well, I think my reference to supportive housing, for example, is a good example where, if the LHIN's mandate was a bit broader, it would allow it to—I'm not sure what the vehicle is to try to coordinate ministries and the funding of ministries, but if they had a role in being able to pull some of these projects together more easily—because quite often what we have is that the LHIN may have funding for some supportive housing but the Ministry of Housing doesn't at that particular point in time. There are a lot of hoops to jump through in some way.

We try to broker those roles at the region, because we have the mandate for housing here, so we're trying to get this group here and this group here, pull them all together and pull the money together at the same time. Somehow, if the LHIN had the ability to perhaps be the quarterback for the provincial side of it in terms of a supportive housing project, maybe that would be helpful.

I really haven't thought it through, but we just know that there's a problem there that needs to be addressed.

Mrs. Christine Elliott: Well, I quite agree with your comment about the government silos, as well. We're experiencing that right now with the Select Committee on Developmental Services, where there are a number of provincial ministries that are involved but they don't necessarily communicate with each other. I think that there are things that need to be changed in government and the way government operates, as well as the way the LHINs operate.

Mr. Ken Seiling: All of our governments have that issue. We work very hard, even at our level, to try to keep silos reduced as much as possible.

Mrs. Christine Elliott: Thank you for your comments.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Fife?

Ms. Catherine Fife: Thank you very much, Chair Seiling, for coming and for raising the issue of the social determinants of health. You're quite right: There does need to be a renewed focus on those factors and how they impact health.

The housing is interesting. This committee is going around the province. We're looking for ways to improve, and you mentioned fine-tuning the LHIN model as it stands because there are great inconsistencies across the province with regard to the LHIN model. Can you identify any particular area around duplication of services that you see that we could bring back as a recommendation from this committee? We are trying to get those admin costs back to the front line. That's a shared goal, I think, of this committee.

Mr. Ken Seiling: Well, I'm always a great proponent of rationalizing services, given my role, and I think that one of the things that the LHIN can do, because it has local—it's always a delicate balance when you're dealing with community groups, because community groups do a

lot of volunteer work. They raise a lot of money, they provide a lot of resources and they have contacts that they have, so it's always a delicate balance of trying to rationalize a lot of community groups doing a service versus keeping them functioning, because if you take away their *raison d'être*, sometimes they disappear.

It's always a bit of a balancing act there, and that's why I think the LHINs are well positioned to be able to do that sort of thing. They have a feel for the community. They're not somebody from 50 miles away saying, "Well, there can only be one group doing this sort of thing instead of three groups."

What the LHIN has done here locally, I think, in some of the seniors' programs—where they haven't been able to necessarily say, "There's going to be one group," what they've done is they've said, "One agency will be the lead agency coordinating that work." For example, in the region, one of the seniors' services is the lead agency in dealing with some of the seniors' services, in an effort to try to coax the best out of the system and avoid some of the duplication that takes place.

As I say, I think it's a delicate balance. We can't do away with all of the grassroots groups, but at the same time I think there needs to be a good examination, a very healthy examination, of what duplication can be removed from the system without destroying the system itself.

Ms. Catherine Fife: Okay. But no specific suggestions from you? Because it's a delicate balance, you know.

Mr. Ken Seiling: That's right. It is.

Ms. Catherine Fife: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair Seiling. We have heard a number of recommendations from deponents that directly affect municipalities. I will share with you what those are, and I'd like your reaction. I'm a former medical officer of health for York region, so some of these were a bit surprising to me.

One was the structural integration of public health units within LHINs—no commentary related to the municipal funding contribution to public health. The other was a recommendation that EMS be integrated into the responsibility of the LHIN. And there was another suggestion that perhaps a municipal member of a council, presumably one, representing the entire LHIN, might be an improvement—to have a fixed position on the board of the LHIN that was a municipal councillor. I'd just like your reaction to those three suggestions.

Mr. Ken Seiling: Well, you're speaking to somebody who's a firm believer that public health units should be integrated in the municipal structure because of the holistic approach. If you separate the health units out, they become—for municipalities, outside bodies become an outside body, whereas we've never fought with our public health. We fund it properly. We have interactions between public health and engineering, for example, water and sewage, and EMS. All of those are integrated together, so we act as a unit. We've broken down those silos instead of setting up bodies. So I would be opposed

to taking the public health units out of our municipal framework.

For example, we talk about determinants of health. Our social service department works very closely with the public health department, because we have a broader view of determinants of health and how they can work together to do those sorts of things. So I would be very much opposed to pulling those functions out and setting them up outside, because then they'd be competitors as opposed to partners in the whole thing.

In terms of putting people from municipal councils on the bodies, that's one I'm not particularly hung up on, one way or the other. I trust the government to make the appointments—and they're community-reflective appointments. I think then you get into a competition, particularly with the LHINs, with their broad areas, about who has which representation and how many numbers there are.

I think the efforts should be put into good health.

Mr. Mike Colle: Every municipality in the region would want a member.

Mr. Ken Seiling: That's right.

Ms. Helena Jaczek: And EMS?

Mr. Ken Seiling: I think EMS belongs in the framework too, because we work with our police services. They have all the supports that are necessary to do those sorts of things. I don't see any value in pulling them out.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Ken.

Mr. Ken Seiling: Thank you, Ernie.

MS. STELLA LEVEAN

MR. JEREMIAH STUZKA

MS. LIA STUZKA-SARAFIAN

The Chair (Mr. Ernie Hardeman): Our next presenters are Stella Levean, Jeremiah Stuzka and Lia Stuzka-Sarafian. Thank goodness that my pronunciation isn't always right but the Hansard will record it perfectly.

Thank you very much for you folks being here this morning. We very much appreciate it. As with other presenters, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you have less than four minutes left, in this case, it will go to the New Democratic Party. If it's more than four minutes, we will divide it equally among the three caucuses. With that, the floor is yours.

Ms. Lia Stuzka-Sarafian: Thank you. My name is Lia Stuzka-Sarafian, just to correct that.

I'm speaking on behalf of my husband, who passed away. Excuse me. His name is Mike—

Ms. Stella Levean: I'll continue with it. These are complaints from the Trinity nursing home hearing.

Mike had heart bypass surgery on October 6, 2010, at St. Mary's hospital. From here, he was released to Freeport, Grand River Terrace, for rehabilitation in November 2010, where he remained until February 1, 2011.

He went home on February 11, 2011, and was living a somewhat normal life until October 23, 2012, when he had a heart attack, with congestive heart failure, and went back to St. Mary's hospital. He was released on November 12, 2012.

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Shortly after returning home, it was determined that, due to poor circulation and an infection in his toe that turned to gangrene, he would also need his leg amputated. Before this surgery, he also suffered a round of gout, delaying the procedure. Surgery took place on November 23, 2012, at Guelph General.

He was then released to Freeport, Union Terrace, for rehabilitation on December 5, 2012—prematurely, as his leg was swelled up like a balloon and he was still very sick. He ended up back at St. Mary's hospital on January 13, 2013, for two days for cellulitis and pneumonia. This proves again that he was released too soon to begin the rehabilitation process, as his body was not in a healthy state indicative for success. He remained in their rehabilitation program until March 11, 2013, when he was transferred to Trinity nursing home.

Mike's physiotherapy at Freeport Union Terrace was inconsistent at best, with the various trips to St. Mary's and the additional blood transfusions required to maintain his white blood cell count. He eventually was making progress, although it was slow.

He was able to transfer from the bed to the wheelchair with a sliding board with assistance; stand from the wheelchair—on January 9, 2013, he achieved this; stand on one leg for 45 seconds, on February 19, 2013; stand on one leg holding onto a rail for 1.5 minutes, in mid-March; transfer in and out of a car with help—he did this on several occasions to go out with Lia.

However, after about six to eight weeks of rehabilitation, around January 25, Freeport Union Terrace decided that Mike was no longer making any improvement and he would need to start looking for long-term care. Although Mike's weight was always a concern for his success, it was brought to the family's attention that it was due to his weight that he was unable to continue at Freeport Union Terrace.

Concerns of the family at this time were: Why was Mike not given an extension for his rehabilitation program at Freeport Union Terrace, given his rough start and continued need for hospital care at the beginning of his stay? Why is being overweight a criterion for discontinuing said rehabilitation?

His weight was an issue and he was told that he would need to lose about 60 pounds to be able to progress any further. Even though all his caretakers knew that Mike needed to lose weight, it was not until January 28, 2013, two months after being at Freeport Union Terrace, that the nutritionist finally spoke to Mike about his dietary needs, to reduce his dietary intake from 1,500 calories to 1,200 calories a day. Even though he was receiving a complete diabetic diet, his calorie intake was not being monitored.

It was discussed with Mike's health care team that Mike's goal was always to come home, and if he was

sent to a long-term-care facility, it would only be temporary, until he was able to successfully transfer and get home. On February 3, 2013, he was told that he was nowhere ready to go home yet, so he should go to a nursing home until he was ready.

These are the concerns of the family about this statement: Why send him to a nursing home if it is nowhere near equipped for the type of rehabilitation Mike required? If he wasn't successful at Freeport Union Terrace, how would it ever be possible for him to be successful at Trinity nursing home?

It was clear that Mike was set up to fail before he was even there. It is at this point of Mike's case where the structure of the hospital system and the policies of the Freeport Union Terrace rehabilitation program threatened to halt the success of Mike's rehabilitation.

After the transfer to Trinity nursing home on March 11, 2013, Mike's progress started to deteriorate. The following complaints are made against Trinity nursing home: the diet plan, the rehabilitation, and the health care.

The diet plan: For Mike to keep his weight under control, it would be essential for him to remain on a strict diabetic diet. At Freeport Union Terrace, this was set up automatically for him. However, at Trinity nursing home, things were very much different. He was given an option of two different meals at each meal time: one was sometimes a healthy option; the other, not so healthy, especially when it came to desserts.

When he chose which meal he preferred, the cooks would then cut the portion in half, thinking it would be sufficient as a diabetic portion. This is not the way to determine a diabetic portion, as no calories, no carbohydrates or sodium amounts were ever taken into consideration. Any certified nutritionist would concur with this fact.

Mike tried his best to select the healthiest option for himself but was often given two poor choices, neither one beneficial to his dietary requirements. Often, meals were too salty or overcooked, thus being too hard to eat, or had no flavour. Some examples of the foods he was given are Campbell's soup, original style, not low-sodium; salmon, overcooked and too hard to eat; roast beef, overcooked and too hard to eat; cheese cannelloni, too salty; Oktoberfest sausage on a bun, too salty and high in fat; and burgers and some fish, undercooked.

In addition, Mike was also not supposed to eat potatoes due to the high level of potassium. However, many of Mike's meals included potatoes even after Lia provided TNH with a list of foods he was permitted to eat which she received from St. Mary's hospital. A copy of this list is available upon request. Mike was given peanut butter and jam sandwiches as a substitute instead of brown rice.

It is without question that Mike was often not satisfied with his meal choices, which forced the family to bring things in to Trinity for him. In the summer of 2013, fresh vegetables were being cut up for him and replenished on a weekly basis. His wife, Lia, brought in several

replacement meals for him for alternative dinner options. A special roast beef was in the freezer for Mike to be used as a meal alternative.

After a few weeks, both these ideas fell through as it became too much of a hassle for the cooks to remember to give Mike his vegetables from the fridge or for him to get them himself. Although the nutritionist knew about the roast beef, the servers would often forget that his roast was there, and when they did, it was often overcooked and too hard to eat.

Many discussions were had between Lia, Mike and the nutritionist, and they did go through a meal plan to determine what Mike did and did not like from their meals list. Although this helped somewhat, it still did not assist with the diabetic aspect required for his diet.

During his time at Trinity, Mike was admitted to St. Mary's hospital two times, in July 2013 and December 2013, for congestive heart failure. In July, Mike and Lia were told by the nurses and doctors at St. Mary's that if his diet was not under control, it would kill him. However, nothing ever changed when he returned to Trinity.

It was in the month of November that Lia and Mike, beyond frustration and noticing the deteriorating health effects associated with his diet, determined to order food in for him from an outside company named Copper County Foods. This ordering started on December 2, 2013, and ended on December 9, when Mike died. The family feels that it was the lack of his dietary needs taken care of by Trinity—no diabetic diet, no consideration of sodium levels in the food and not checking for his fluid intake—that caused him to be sent to the hospital on both occasions, which did end in his death.

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The transition process for Mike's rehabilitation from Freeport hospital to Trinity home also demonstrates how the system breaks down and inhibits Mike's full recovery. Mike was sent to Trinity nursing home on March 11, 2013. It took them over a month before he was set up with his first rehabilitation session. This 30-plus-day delay did not assist in his progress but in fact put him in a relapse state. When he finally began his sessions on April 15, 2013, he was not able to start off where he had left off at Freeport Union Terrace because he had to start back at the beginning. He mentioned several times that he had lost all the strength in his arms and could not even do any lifting up from his wheelchair.

Worse than that, Trinity nursing home only offered basic daily muscle movement to prevent patients from losing muscle mass and becoming atrophic. They gave him two-pound weights that did nothing to help Mike improve his strength. He needed to be able to lift his whole body up from his wheelchair. This program was not going to get him able to do that.

Trinity nursing home also did not have the physiotherapy equipment that he needed to practise the transfers as he did in Freeport. This is another reason why he should have remained at Freeport Union Terrace. To try and increase his rehabilitation efforts, he was put on a

waiting list to start back at Freeport Union Terrace as an outpatient two times a week.

The concerns of the family about this transition from Union Terrace to Trinity were:

—Why was there such a long delay in getting him started on rehabilitation after he moved into Trinity nursing home?

—Why did he need to be put on a waiting list for rehab at Freeport Union Terrace as an outpatient? This should have been set up and organized before he was transferred over so there would be no delays in his program.

—Knowing he was not going to get what he needed at Trinity, steps were also taken to sign up for rehab programs at St. Mary's hospital, which he attended after his heart biopsy. He too was on a waiting list here, and was eventually told he did not qualify for the program.

—His rehabilitation program as an outpatient at Freeport finally did resume in May 2013 until July 2013, and September until November 2013.

Why was his rehabilitation program ended when he again was not able to go home? This is where he should have received numerous repeats until he was ready to go home. The doctor knew at Trinity that Mike had congestive heart failure, diabetes and the beginning of kidney failure, yet the progress of the symptoms of serious kidney failure were not noticed by anyone or discussed with the patient or the family.

On November 10, 2013, Mike was not feeling well. He was shaking so much that he dropped the phone three times in a five-minute span when his daughter Tina tried to call him. She called the nurses' station to see what was wrong with him, and as this was a very unusual behaviour, she was told by the nurse that she would check his vitals and call her back. She did, and said that all his vitals were fine and suggested that he was very tired because he hadn't been getting much sleep. Something was obviously wrong at this time, but it was uncertain what the reason was. In retrospect, it was quite likely that his kidneys were starting to fail more rapidly, but nothing was followed up on this with his kidney specialist. In fact, I am learning just now that he hadn't seen his kidney specialist since the beginning of the year. Why would he have not followed Mike on a regular basis to monitor his kidneys?

When Mike had his cataracts removed on November 14, 2013, Mike was feeling very nauseated and was given Gravol. However, upon reading all the symptoms of kidney failure after the fact, it turned out that Mike was experiencing severe symptoms of kidney failure at this time. It was nausea, fatigue, shortness of breath and itchy skin. I'm not sure what his blood results were to see the protein level, but my guess is that they were off.

He was admitted to St. Mary's hospital on Thursday, December 5, and lost consciousness on Friday, December 6. He died on the ninth due to kidney failure.

The many questions from the family are below:

—Why was Mike dismissed from Freeport Union Terrace in the first place when he was not successfully rehabilitated to go home?

—If only so many days and weeks are allotted per person in Freeport Union Terrace, why was he sent to a long-term-care facility which could not provide him with the necessary rehabilitation to get him home?

—Why did the doctors and nurses at Trinity nursing home treat him as a regular resident who would be remaining at Trinity nursing home, instead of trying to assist him in getting back home with the type of care he needed to do so?

—What can be improved in the system so that this doesn't happen to anyone else?

—Why are diabetic needs not considered vital needs inside nursing homes? Why is it not mandatory and not voluntary?

The Chair (Mr. Ernie Hardeman): Thank you very much for that heartfelt presentation. I wish the committee was able to answer those whys at the end of it, but our review is on the big picture. But I commend you for making the effort to be here today to bring that forward, so thank you very much for your presentation.

Mr. Jeremiah Stuzka: If I can just take 10 seconds really quick: One thing that was brought up by me with many of the health practitioners that were working with Mike was the idea of his mental care. Anybody who has poor thinking abilities is going to make poor choices. If his thinking isn't put into perspective, on his own he's not going to do anything. You guys never—I'm sorry that I just wasn't better prepared. I think the point's been made.

The Chair (Mr. Ernie Hardeman): I appreciate that, but we do have to keep everybody on the 15-minute limit. We do, as I say, appreciate the time you have taken to bring that forward.

HOME OF THEIR OWN

The Chair (Mr. Ernie Hardeman): Our next presentation is Home of Their Own: Moira Hollingsworth, Deborah Pfeiffer and Sue Simpson. Good morning, and thank you very much for coming in. We appreciate that. You will have 15 minutes to make your presentation. You can use any or all of your time. If you leave time less than four minutes, it will go to the third party for comments and questions. If you have more than four minutes, we'll divide it equally among the three parties.

With that, thank you again, and we look forward to your presentation.

Ms. Sue Simpson: Thank you. Members of the standing committee: Good morning, and thank you for the opportunity to speak to you today. My name is Sue Simpson, and I'm here this morning with two other mothers, Deb Pfeiffer and Moira Hollingsworth, to share our story.

We are three families with adult sons with developmental disabilities living at home. We came together five years ago to discuss concerns about their future housing needs, which will become critical as we, their primary caregivers, age and can no longer care for them at home.

In April 2011, we purchased a home for our boys in Waterloo, and our goal is to secure funding to allow them

to live there full time. Currently, with support from Elmira and District Association for Community Living, they spend one respite weekend there per month.

In the 2006 ministry document Opportunities and Action: Transforming Supports in Ontario for People Who Have a Developmental Disability, the Ministry of Community and Social Services acknowledged the need to encourage families to work collaboratively with service providers, the community and other families to create innovative alternatives for residential support. It cited examples of models that included joint family creation and ownership of housing and pooling of family resources in conjunction with MCSS dollars to create homes in the community for their family members.

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So that's exactly what we did. We came together with each other and a service provider and created an appropriate housing option for our vulnerable sons, all of whom have very high needs. We are still waiting for funding.

We are aware of many other families who are concerned about the lack of suitable, person-centred residential opportunities in our community. There were a large number on the former developmental services access centre waiting list for residential services who are now registered through Developmental Services Ontario as interested in and requiring residential services. This list continues to grow, with no apparent ministry plan or strategy to address it. Money has stopped flowing to agencies for the creation of more group homes, but families cannot obtain funding for other creative options.

We do acknowledge and appreciate the positive steps taken by the ministry in recent years to give families more choices in day supports with the creation of the Passport Program for adults with developmental disabilities. There is also potential use of the federal Registered Disability Savings Plan for their future financial needs.

I also came here today with my son and his support worker, Aaron. My son is Kevin, and Aaron is his support worker there at the back of the room. Kevin is 24 years old. He lives with my husband, Mike, and me in Kitchener. We recently had to sell our family home of 20 years in Waterloo to address our accumulated debt related to Kevin's profound needs. We unfortunately had to choose between a future home for our son and the home that our children grew up in, as we could no longer maintain both. We believe so strongly in the home that we have created for Kevin, and we now have to rent a family home.

Kevin has cerebral palsy, profound developmental delay, epilepsy and chronic asthma that can result in mucous plugs and respiratory distress if not carefully managed. He is referred to as being medically fragile and technologically dependent. Kevin has an open stoma, which requires cleaning and monitoring. He is non-verbal and uses a photo schedule for receptive communication and a voice output device and body gestures for expressive communication.

When Kevin finished high school at the age of 21, despite his significant needs he was put on a waiting list

for Passport funding for a year. We paid out of our own pocket for the necessary one-on-one support needed five days per week for that full year. Existing day programs were not suitable for Kevin, due to his need for one-on-one support and the inability to meet his physical activity needs in order to maintain good health. Existing respite programs were not appropriate either. His medical needs were too high for one, and he was too mobile for the other.

Kevin enjoys life and participates in various community opportunities to fill his days with meaningful activity. He is generally a happy, active individual with an engaging smile and laugh. Kevin is always out and about in our community. In fact, some of you may have seen him swimming, listening to music, going to the library, skating, sledding, bowling, playing blastball and basketball, or attending sports and music events.

Kevin, like all members of our community, has the right to be treated with dignity and respect and to have choices. As caregivers of adults with developmental disabilities, we feel it is essential to make sure that our adult children live in a safe, happy and secure environment. We cannot rest as parents until this goal is accomplished. Our supports intensity assessments are supposed to be tied to the levels of support that indicate funding equivalents of \$80,000 to \$90,000 per individual per year, if we look at precedents set historically for the creation of group homes.

We are asking that the ministry fulfil its commitment, as promised in 2006.

Ms. Deborah Pfeiffer: Good morning. My name is Deborah Pfeiffer. My son, Hayden, is 20 years old, and it seems like just yesterday I was walking him to JK. He will graduate high school this June, and at that time, his father and I will be responsible for developing a program for him, as there are no suitable programs available for him.

He also requires one-to-one support. Those support dollars will be paid for out of pocket by us at roughly a cost of \$450 per week. In a year, it is over \$22,000 that we will need to come up with on an annual basis, along with the additional costs of maintaining Hayden's home, which does not include operating dollars.

We, like many families, struggle with what will become of our children when we are no longer able to care for them. Our sons are growing up and we are aging, with no answers in sight. I don't want to be in my senior years still struggling with where and with whom Hayden will live. I need to know that his good life will continue long after I am gone.

We, as families, are willing to do our part, but we need the support of operating dollars in order to make this happen.

Ms. Moira Hollingsworth: Good morning. My name is Moira Hollingsworth, and I'm here today with my 30-year-old son, Ian, who is sitting in the back there with his support worker. As with Kevin and Hayden, Ian is non-verbal and requires 24/7 support. His primary diagnosis is autism, and he also has epilepsy.

Like Kevin, who is also here, Ian has some funding, which partially covers the day supports that we have in place for him. We supplement this to make sure he's as active and stimulated as possible.

My husband, Roger, and I are now in our 60s and feel more urgency now that we must have a safe, secure home for Ian before we are unable to take care of him ourselves. In fact, we feel we cannot retire until we have this in place.

Ian has been on the developmental services access waiting list for 22 years. In that time, he was never offered any kind of residential placement, because that list really only serves those families who are in immediate crisis. We always wanted for Ian something that we chose for him, with people he was compatible with.

In the last five years, we've worked very closely with the executive director of Elmira District Community Living, Mr. Greg Bechard. I've attached in the notes his own submission on our behalf about our group, which is called HOTO, to the developmental services committee.

I just want to reiterate what Sue mentioned earlier, that in the legislation of 2006, it was certainly implied that the ministry was no longer in the group home business and that we, as families, should collaborate with each other and be creative to come up with something of our own, and this is what we've done. We've purchased a home. We've each put in \$52,000 in the last few years. But because of the high needs of our sons, we do need those support dollars as well. There are major health issues involved here, as well as the developmental delays.

We would hope that this committee would make recommendations to the Legislature that there needs to be some process by which we can obtain the type of funding we need.

We would be happy to answer any questions you might have today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes. We're going to start with the third party. Ms. Fife?

Ms. Catherine Fife: Thank you very much, Deb, Moira and Sue, for coming forward and sharing your story. So, essentially, you want this committee to make the government do what they said they were going to do back in 2006. Is that right?

Ms. Deborah Pfeiffer: That's correct.

Ms. Catherine Fife: The \$52,000 that you've each invested to create a group home for your children: How is this sustainable? Many people in the province can't do it. I know, Sue, that you've actually had to sell your own home. Can you tell the committee a little bit more about the personal and financial sacrifices that you've made to follow through on this plan from 2006?

Ms. Sue Simpson: Sure. As I did say previously, we did have to sell our home. It was a very difficult decision. It was another move for Kevin that's very difficult, but we were not able to continue to pay for the new home that we're creating with the other families, and it was an essential decision that we had to make. It was extremely difficult and heartbreaking, but we believe very strongly

in the opportunities that we're trying to create with these other families, and it was worth that sacrifice.

Ms. Catherine Fife: A quick follow-up: If the operating dollars don't come from the government, as was promised, what will happen, then, to your children? What is the future for them?

Ms. Sue Simpson: We don't really know. The expectation from the ministry is that they will live with us. They can't live with us. Their needs are so significant, and having to monitor them 24/7 is just not possible to do, especially as we're aging. My husband was very ill two years ago and almost passed away, so that brought things to a real head for us, to realize that this is the reality of our situation.

Ms. Moira Hollingsworth: In our case, too, my husband turned 65 this year. We just can't sustain this forever, and we don't want to be in a position where we are unable to make the right decisions for him. We have to do something now to make sure that our son's needs are looked after while we are capable and able to do that. Time is running out.

Ms. Catherine Fife: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mrs. Cansfield?

Mrs. Donna H. Cansfield: Thank you for your presentation. I think you identified a number of areas where we actually need to do some significant work.

First of all, I want to say thank you, as well, for taking the initiative around purchasing a home, finding a place for your children, and looking to their future. That's a hard decision to make as parents, but kudos to you for having done that. Now the situation becomes: How do we manage that with you? I think we do have a role to play in that.

I think you also identify something that's really critical. I've been in this for 26 years, and for 26 years it's the same problem: What happens when they're 21? They fall into this chasm until they're 22 or 23, but that one year is really, really difficult. We still haven't managed.

That's one. The other one I think you identified is that we have three different ages for these young people—16, 18 and 21—depending on which ministry you're in, which also creates an enormous issue around accessing programs and funding.

Again, I think what you've done is raise a significant issue. I believe that Mrs. Elliott probably has more that she'd be able to share with you, because she's on a panel looking at this. Unfortunately, our mandate restricts us just to the LHIN capacity. Maybe that's a discussion or a place you should go.

The Chair (Mr. Ernie Hardeman): We'll now go to Mrs. Elliott.

Mrs. Christine Elliott: Thank you for coming to present to us today. As Mrs. Cansfield has indicated, we're not able to really deal with that specific issue because we're dealing with the LHIN review right now, but we do have a select committee that has been established at the Legislature to look at developing a compre-

hensive developmental services strategy. I'm pleased to be the Vice-Chair of that committee.

1030

Sadly, I have to say that what you're telling us is happening across the province. We are in crisis right now. We are not serving you or your children well at all. We've heard about the problems with a lack of respite; it sounds like you've had a little bit of respite help, but in many places across the province there isn't any respite.

There are no opportunities for young people after they turn 21; it's like they fall off the edge of a cliff. There are no day programs or employment opportunities, and of course housing is the biggest issue of all. We've heard from families who've had to drop their children off at developmental services offices because they've not been able to care for their needs. We know that even though you can qualify for Passport funding, the reality is that there isn't any money there, so it really doesn't serve any purpose.

All I can tell you is that this is something that a number of us around all three parties feel very strongly about. We are taking this very seriously, and we are going to be writing a report that is going to advocate for major change in the system. We've just concluded our public hearings, and we are going to be completing an interim report by the end of February that will basically summarize what we've heard so far. Our final report will be coming out in May, and we will be speaking to the very issues that you've been discussing.

I really applaud you for the innovative, proactive approach that you're taking to finding a place for your children. We need to give you the support that you need to make that dream come true for them. I'd love to hear more about it, so perhaps we can chat offline. Thank you very much.

Ms. Moira Hollingsworth: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you for your great presentation. We very much appreciate you making the effort to come here and talk to us even though this wasn't the committee that's going to be able to solve your problems. At least you're getting the word out there that there are problems there.

Ms. Sue Simpson: That's right. Our goal is to increase the awareness. Thank you.

MS. DENISE JENNINGS

The Chair (Mr. Ernie Hardeman): Our next presenter is Denise Jennings. Thank you very much for coming in this morning. Like all the others, you will get 15 minutes to make your presentation. You can use any or all of that time for your presentation, and if there's less than four minutes left over at the end, that will go to one caucus; if there's more than four minutes, we'll divide it equally among all the caucuses. With that, the floor is yours.

Ms. Denise Jennings: Thank you. Good morning. I'm Denise Jennings, and this is my husband, Dwayne. We're here talking as parents today. We have concerns about the youth mental health system.

My husband and I journeyed through the labyrinth of the youth mental health system with my son from the time he was 11 until he was 18. In our estimation, the youth mental health system in this region has a number of huge cracks ready-made for youth to fall through, and we know all too well the tragedy that can ensue. I think our experience reflects all the good, the bad and the ugly that the system has to offer, and I'm hoping that in sharing our story with you today, it may spark some resolve for improvements.

I'll leave you to read the grim statistics about youth mental health. I think the most striking one is that it's the number one cause of non-accidental death for Canadian youth. Despite the enormity of that problem, there's little help. Only one in four kids will get the help that they need, and the wait is very, very long. This may have something to do with the fact that funding for children's mental health amounts to only 1% of the total health care budget.

Sadly, our beautiful boy became a statistic. This is our son Iain in the early days, before he became ill. Our son was a gentle soul. He had lots of fun and lots of friends, and he was loved by many people. He did have a number of mental illnesses, though, that were linked together and that increased in severity as he got older.

He had an illness. He didn't have a mental health issue. I can't stand the term "mental health issue" because I think it's really too soft a term for the hell that these youth go through. "Mental health issues" suggests that something can easily be done to overcome them—a few little programs, a couple of parenting sessions, perhaps, or just better parenting in general. Certainly, issues don't get as much funding as serious illnesses such as cancer or cystic fibrosis.

What my son had and what many other children suffer from are brain-based neurological disorders, which, when left untreated, can cause high rates of lifelong disability and can result in death. Treating mental illness requires a combination of research, proper medications, expert team interventions and skill development directly with the kids who suffer.

I'll leave you to look at this slide. It's from the World Health Organization and it really just reflects the magnitude of life-long disability caused by mental illness.

As I mentioned before, there has been the good, the bad and the ugly in our journey with Iain. From age 11, we knew that he needed help but we were hard pressed to find it. We did finally see the good, but it arrived much too late, after five years of trying to get help through the Ministry of Children and Youth Services.

The good came from LHIN-funded services, in fact—services that were funded under the Ministry of Health and Long-Term Care. LHIN-funded services were only accessible, though, at the end, when my son was 16 and was very ill. He had become psychotic and delusional. He thought he was being followed and filmed. He non-violently—I'll stress "non-violently"—approached someone whom he had incorporated into his delusional system, and he was charged with harassment. The police

realized he was mentally ill and they took him to hospital, but unfortunately, after being in hospital for a while, his next stop was jail because secure treatment units were unavailable.

Iain did receive expert assessment and care at Grand River Hospital in the child and adolescent unit. They knew he was lacking in judgment and they knew that parents needed to be appointed as substitute decision-makers at that time. This unit then referred Iain on to the best service that we experienced, and that was the first psychosis early intervention program. I wish Iain could have been involved in a service like this much earlier. I think it would have made a world of difference.

1040

Again, this is a LHIN-funded service. This service was excellent on a number of fronts. It was one-stop shopping; it was a well-integrated service package. It was treating illness, not an issue. The team had expertise in psychosis. They used evidence-based treatments. There was psychiatry consultation. There were intervention programs directly for youth. I think the most important thing is that they used an assertive outreach. That team realized that they were treating a serious illness, that the consequences of leaving a kid to languish as ill were serious, and they did not give up easily. They were at our house come rain or shine. They came in hospital, they came in jail and they kept in touch with Iain. But really, it was too little, too late.

The bad: The bad is that youth mental health is one confusing system. There are no guides and there are a lot of hard stops along the way. We lived in this labyrinth for five years, and what follows are some of the biggest frustrations that we experienced. Our son had an illness as serious as childhood cancer, as serious as cystic fibrosis, but services fell under the Ministry of Children and Youth Services. You can see from this ministry's mandate that it's broad, diffuse and mixed. The focus is on solving social issues, not on treating mental illness. Accordingly, after a very long wait, the only help provided was education and parenting support. There was no direct treatment for Iain, and I really think earlier on he needed direct treatment and he could have benefited the most at that time.

Fragmentation: As a parent, when your child is ill and out of control, you try to access everything you possibly can but you hardly know where to start and nothing seems connected. Even if they're housed under the same service umbrella, there are these lengthy intake procedures that need to be completed many times in many places. Early on, our son did have a few minor scrapes with the law, and this often comes with the territory with kids who have ADHD—the impulsivity, the increased substance use with that particular disorder. We knew that there were programs for mentally ill kids in conflict with the law and there were certainly lots of mental health workers at court, but we were not able to get connected up with any kind of intensive supervision and support program that would have helped him at that time.

There's a huge gap for 16- to 18-year-olds. In theory and on paper, they say that services go up to the age of

18, but if your child is sitting on a wait-list and he's 17, he may be passed over for services. And if he's complex, difficult to treat or a little bit surly, they may even sit on that referral until he ages out of the system.

There are also many critical services that stop before age 18. There's Ray of Hope youth addiction services; it stops at 17—a lot of the residential treatments and a lot of the in-patient mental health treatments as well. So in that critical period between 15 and 24 years of age, youth will be switched between ministries and they'll be switched between services, and they're probably going to fall through the cracks.

Mental illness and substance abuse often go hand in hand, and they need to be treated concurrently. Unfortunately, the system in Waterloo region is not set up for that. If a kid happens to have both psychosis and a mental illness, you're out of luck. You've got a problem. The concurrent disorder forms the basis for exclusion from either service stream.

Early on, our son would have benefited from residential treatment, but there was none to be had. He wasn't going to school. There weren't any alternative schooling programs. He was becoming very difficult to manage at home and he was engaging in risky, impulsive behaviours, often fuelled by substance use. We were unable to sleep at night because we didn't know about his whereabouts or his safety. Despite our best efforts, we were not able to keep him contained. There was absolutely no hope of getting residential treatment at this point, so we had to resort to a boarding school for kids with learning disabilities and behaviour issues. This was not mental health and addictions treatment, and it was expensive. And I'm afraid a lot of parents, out of love and desperation, go that route and end up paying \$40,000 to \$80,000 a year for what are pretty dodgy, unregulated services. If you can't borrow that money, what do you do?

This is the most important point: the fact that there's insistence from many services on youth consent for treatment before they receive services. You're on a wait-list for months. You have a child who's ambivalent about services. Providers come in and they stress his need for consent; child consent is paramount. He says no; service gone. Your chance for help goes out the window. It's a huge problem. It's iffy whether healthy adolescents have the capacity to understand risks and benefits and consequences. When you add mental illness in on that, it becomes even more risky. The most difficult kids to treat are going to say no, and it's no surprise that agencies might be a little bit relieved when they do say no.

The ugly truth is that our child, because he was charged because of a mental illness, spent six months of his short life in secure youth custody. There was no place for him to go. The folks in youth custody were very nice, but they'll be the first to tell you that they know absolutely nothing about treating youth mental illness. And while in jail, Iain was very sick. He was very psychotic. He thought his room was bugged. He was putting papers over cameras and vents and so on. We, as

parents, could only see him for two hours a week. Halfway through the six months, he did come out of jail, but there was no follow-up from the youth addictions services, and he relapsed and he became psychotic and he went back to jail again.

We had to get him out of there. We tried to get him to Regional Mental Health Care London, but we had to go through this committee of the Ministry of Children and Youth Services to get him there, and that took months. So on our own, we pleaded with Ontario Shores, and he did finally get into residential treatment. He was there for three months, and he did get better, but too little, too late.

Iain is one of the statistics here; 60% of the kids in juvenile detention have a mental illness or addiction, and he was certainly one of those. You can see how mental illness is becoming criminalized and that a lot of people in jail have mental illness or addiction. As you can imagine, a downward spiral ensued. He comes out with the dual stigma of having a mental illness and being perceived as a criminal. He fell through the cracks.

The First Step program was still there, but they weren't big enough to manage the complexity of the problem.

One day, Iain went missing. Several days later, he was found dead. Adding insult to ugly, we got a request from the Ministry of Children and Youth Services to complete a satisfaction questionnaire, and this came the day before our son's funeral. I did respond to that—rather curtly, I might add.

We have recommendations. We never want this pain and hardship to happen to any other parent or any other child, and we hope this never happens again to anyone else, so our recommendations are:

—Please treat mental illness as an illness and fund it under the Ministry of Health and Long-Term Care. Hopefully, there will be coordination and accountability there.

—Funding needs to be proportionate to the magnitude of the problem. This is a huge problem for youth, and it has high mortality.

—Treatment for mental illness, instead of incarceration: It's much easier to get into jail than it is to get into treatment, unfortunately.

—I hope this can be looked at: There needs to be a mechanism for parents to get help for non-consenting minors long before they come to the point of imminent harm to self or others.

That's what we have to say. Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much again for that heartfelt presentation. We very much appreciate that. Obviously, it fits right in with the committee's work as to how we need to do a better job of coordinating the services that are available, to best serve the people that need them. Thank you very much for your presentation.

Ms. Denise Jennings: There's also a rant on consent on the back page. I think it deserves a look. It's a huge problem.

The Chair (Mr. Ernie Hardeman): Thank you.

SERVICE EMPLOYEE INTERNATIONAL
UNION HEALTHCARE CANADA

The Chair (Mr. Ernie Hardeman): Our next delegation is Service Employee International Union Healthcare Canada: Abdullah BaMasoud, research and health policy, and—there's another one—Emanuel Carvalho, vice-president. Welcome to our committee. As I've said to some of the other delegates, if I mispronounce the name, Hansard will print it perfectly, so not to worry.

Thank you very much for being here. You will have 15 minutes to make your presentation. You can use any or all of that time. If there's time left over but less than four minutes, it will go to one caucus. If there's more than four minutes, then we will divide it equally among our caucuses for questions.

With that, the floor is yours. Thank you again. We're interested to hear your presentation.

Mr. Emanuel Carvalho: Thank you, and good morning. My name is Emanuel Carvalho. I'm the executive vice-president for SEIU Healthcare. I am accompanied by my colleague Abdullah BaMasoud. He is our health policy and economics researcher. I'd like to thank the committee for giving us the opportunity to be here this morning.

We are with SEIU Healthcare, an organization that advocates on behalf of over 50,000 health care workers across the province. Our members work in hospitals, nursing homes, retirement homes, and in the community and home care sectors, which gives us a unique perspective across the spectrum of care in the health care system.

Our membership is diverse in population. It includes personal support workers, registered practical nurses, RNs, health care aides and a variety of other front-line health care workers, including DSWs, who work in the mental health sector.

As an organization, we're committed to forging constructive partnerships with health care providers and with other stakeholders to find innovative solutions that drive quality and value while maintaining our public health care system. The overwhelming majority of our 50,000 members work for health care providers that receive a good chunk of their funding through the local health integrated networks.

1050

In my time today, I'd like to talk about three aspects of the LHINs that we think must be addressed in the future amendments to the LHINs act.

The first aspect is accountability for taxpayer money in the home care sector. In the last few years, the home care sector across the province and its funding have grown to meet the increasing demands of our aging population. Investments in these services are projected to increase by over \$700 million over the next three years, including \$260 million in the current fiscal year.

Home care has been identified as vital to improving health care outcomes while constraining expenditure growth in the more costly acute care and long-term-care

sectors. As Ontarians age, demand for home care services is projected to continue to grow. Academic studies show that the demand for formal care in the home setting, such as personal support services, is projected to double by 2031.

The legislation gives the LHINs the authority to fund hospitals, long-term care, mental health and addiction, community health centres and community support services, including the community care access centres, the CCACs. The LHIN act requires LHINs to enter into service accountability agreements with service providers. The accountability agreements with the CCACs require that the CCACs do not spend more than 10% on management and administration. We think that's a good thing; however, such accountability requirements do not extend to home care agencies, which receive the most part of the funds transferred to the CCACs. Currently, only a fraction of home care funding finds its way to front-line care.

Our analysis, based on data from the Ministry of Health and Long-Term Care, health data branch, shows that approximately a third of each public dollar is absorbed by private home care agencies for expenses that include executive compensation, CEO bonuses, administrative costs and profit margins. With hundreds of millions of public dollars being funnelled into the home care sector in these lean times, taxpayers want to see a higher return on their investments in the publicly funded and privately delivered home care services.

Increasing financial efficiency in the home care sector is crucial for the province to see a higher return on its investment in the home care service, that is, to see more hours of personal support care for the same amount of funding.

We believe that the LHINs should require that public funds transferred to the CCACs aren't spent to inflate corporate profit lines or CEO perks. LHINs should require that any agency or corporation that receives funds from the CCACs to provide publicly funded home care services should spend at least 90% of every taxpayer dollar they receive on clients, with no more than 10% that is spent on administration or scheduling of the contracted services. This is not an unprecedented expectation.

In the long-term-care sector, funding is given in what is known as funding envelopes. Three of the funding envelopes are recoverable, that is, unspent money in that envelope is returned to the public funder.

We appreciate that this review is about the LHINs act and, therefore, we recommend expanding the LHINs act, part IV, funding and accountability responsibilities, to set requirements that contracts between the CCACs and home care agencies that receive the bulk of the home care funds reflect stewardship of taxpayer money.

The second aspect of the LHINs act is community engagement and consultations. The act requires that the "local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing

basis, including about the integrated health service plan and while setting priorities.”

However, LHINs have been criticized over and over for failing to conduct meaningful consultations with Ontarians. The secretive process that LHINs use for health facilities closures, in particular, drew frustration from the public. Closing the Revera Thunder Bay nursing home in 2012 and the hospital restructuring in the Hamilton-Niagara region are but examples of the process that caused an uproar among locals.

This perception is shared by the Ontario Ombudsman, who, in 2010, slammed one of the LHINs for a secretive and meaningless consultation process. The Hamilton Niagara Haldimand Brant LHIN held over 11 closed meetings over hospital restructuring without access from the public. In the North West LHIN, the closure of the nursing home in Thunder Bay resulted in a loss of 55 long-term-care beds in a community that is underserved and that has the longest wait time for long-term-care beds in Ontario.

There is a need for a clear minimum standard required by the LHIN to meet for soliciting community views on regional priorities or for future integration plans. We recommend that such engagement requirements include meetings with representatives of client and patient advocates and labour organizations that represent health care workers, as these two types of organizations deal with front-line care providers and care receivers.

The third aspect is transparency. When the LHINs were created, the health minister at the time, Mr. Smitherman, said that the requirements of the community engagement by the LHIN would make it “very clear that decisions must be made on the basis of public interest and in the full view of the public.”

As the Ombudsman said, “LHINs must make difficult and sometimes unpopular decisions about health services. They will never please everyone. But people will be left confused, dissatisfied and distrustful unless the process is open and transparent. The integrity of the LHIN system across the province depends on it.”

Last December, the Hamilton Niagara LHIN refused to disclose the background material for board meeting agendas to a local newspaper. To make the decision about it, the 14 LHIN chairs met to discuss whether they should disclose the background material for board meeting agendas. They have reached a decision wisely; the CEO of the Hamilton Niagara LHIN decided to release the material after all. On the other hand, the Erie St. Clair LHIN not only shares information about meetings, it also has webcast meetings and invites citizens to participate during open-mike sessions. Such great differences between LHIN practices highlight the need for the province to set clear standards on what Ontarians may expect in terms of transparency and openness. It is clear that different LHINs interpret the transparency expectations differently.

We see the model by the Erie St. Clair LHIN as an example for a transparent network, and we’d like to see it replicated at the other 13 LHINs and mandated in the LHIN act.

I want to thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have five minutes left, so we will start with the government. Mrs. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. I think you’ve identified an area that has had some consistency in other presentations, and that’s the inconsistency in and amongst the LHINs in terms of their mandate. They all have the same mandate, but they all seem to interpret it somewhat differently.

The area around consultation and disclosure is absolutely paramount, as you identified, for engagement in the community for those very difficult decisions that sometimes have to be made. It’s interesting in this day of communication that we don’t do a very good job at this. But you must have some ideas how you think we could in fact present some recommendations or some models around how that consultation should take place. You identified one particular LHIN that seems to be doing fairly well. Are there other examples where you think we could improve in terms of consultation?

Mr. Abdullah BaMasoud: I’ve attended a few of the LHIN public consultations, and sometimes in the room there would be more LHIN staff than public in attendance. So you’d have up to 10 of the LHIN staff, and maybe five or six attending. We are based in Richmond Hill, yet when we held an event for the public here in Kitchener, we had close to 80 attending our event. I think that part of it is doing proper work, your own work, right? If you want to reach out to the public, you have to find ways, mechanisms to reach out to them, either through organizations that represent the clients and stakeholders—and reach out to them and make sure that they also communicate to their own audience to solicit their input in whatever you’re consulting them on.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott.

Mrs. Christine Elliott: I’d also like to thank you very much for your presentation. I found the idea of having the minimum standards for consultation to be a very good one, because there is so much discrepancy among the various LHINs. But I wanted to ask you a quick question, if I could, about putting more people into the front lines and some of the concerns with the CCACs.

As you may know, the Registered Nurses’ Association of Ontario has made a recommendation to basically collapse the CCAC into the LHIN and to have the case managers basically working on front-line service and less on administration. Do you have any comments on that? Do you agree with that, or do you think it’s a worthwhile idea?

Mr. Emanuel Carvalho: I’m not sure if I agree with the total argument that they’re making at this point, because I’m not really too familiar with their arguments, but it has been a consistent argument of ours that the system, in some ways, is cumbersome. It just doesn’t make sense. When we ask people about the system itself, there isn’t really a clear expectation of what group does what. What we do understand is that there’s a lot of

funding coming down from government and there are all these layers, and it's almost like a filtering process that happens.

The bottom line is what we deal with on the front lines. We have governments out there doing the right thing, in our opinion: putting the funding into the home care system. The problem is, when the money gets into the system and it goes through that leaching process, it doesn't hit the front line. In fact, there's more money going into the system but we have members telling us they're being laid off. How is that possible?

So there are some real problems with the system. We find it to be cumbersome, and we do have to fix it.

Mrs. Christine Elliott: Thank you.

1100

The Chair (Mr. Ernie Hardeman): Ms. Fife.

Ms. Catherine Fife: Thank you very much for the presentation.

Around the transparency and accountability around the funding: It's not always easy to find out where that money is actually going. You did reference one relatively alarming piece of data: that one third of some funding around long-term-care homes is going to executive compensation and profit margins. Certainly, that's not the goal of those health care dollars. Do you want to comment on that?

Mr. Abdullah BaMasoud: I just want to clarify. Our analysis looked at the home care funding, not the long-term-care funding. In the home care funding, you have different layers. The money comes from the ministry to the LHIN. At the LHIN, it's pretty much an accounting exercise—transfer that money that is earmarked for home care to the CCACs. The CCACs take about 10% for administration, and then about 20% is spent on case management for home care clients; that is, assigning them the hours etc. Out of that 70%, we estimate, based on what we know about what PSWs make and what benefits they have etc., that only 41% of that 70% goes to front-line care; and that 29% is somehow absorbed by the private agencies, whose role is not case management, which is a pretty expensive role. The role is just the scheduling and hiring and—

Ms. Catherine Fife: That's right. So it's really going to profit margin—

The Chair (Mr. Ernie Hardeman): That concludes the time. Thank you very much for your presentation.

GRAND RIVER HEARING CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is Grand River Hearing Centre: Calvin Staples. Welcome. Thank you very much for being here. You will have 15 minutes, and you can use any or all of that for your presentation. If there's less than four minutes left over, it will go to one caucus; if there's more than four minutes, we'll try to divide it equally among the three caucuses. With that, the floor is yours.

Mr. Calvin Staples: Thank you for your time. I'm a little unfamiliar with this format, so I'll try to be as quick

as I can in respect of the time that you are dedicating today.

As I was introduced, my name is Calvin Staples. I'm a local citizen. I'm an audiologist. I'm a business owner. I coordinate, teach and run the hearing aid program at Conestoga College. So I'm relatively busy, but at the same time, I thought, as I was invited to come here, that this was something that should be brought up to the government and the players who are at the table today.

Approximately six months ago, I contacted a local MPP with regard to some of the changes that are going on in our province's support structure for those who require hearing services. As an audiologist, I'm all too familiar with the social, financial and emotional losses that accompany untreated hearing loss. I'm not sure if anyone has been following some of the stuff that has been written in the *Globe* or the *New York Post* lately with regard to untreated hearing loss and its linkages to depression, dementia and social isolation. They're not just kind of related; they're extremely correlated. As our population ages, the need to look at hearing loss and how we treat that is very important.

In 2013, the Ontario Disability Support Program, along with Ontario Works, started to make some changes to their funding schedule. The changes resulted in a system that I believe is less effective, less efficient and less focused on the needs of Ontarians who rely on these services. If I can borrow some words from our local MPP, the new policy also violates the principle of choices embedded in our health care system. I'll explain what the new policy is in a second, but I'll go a little bit further here.

The new policy actually asks those who are in financial need to seek out a second quote to cover the costs of devices. Many times, the cost difference to the taxpayer is actually negligible, and thus it costs the taxpayer more money, as the agency then pays for transportation costs as well.

Ignoring the proximity of the clinic to the patient's home—hearing health care is an ongoing process which requires many appointments, and thus, the costs can become quite substantial. In order to actually properly treat hearing loss, it needs to be an ongoing process that actually fully entails all aspects of hearing health care.

As a taxpayer, I totally respect the need to be sure that the funding is allocated appropriately. However, with our current system, we have non-hearing health care workers who admit to being completely untrained, making hearing health care decisions. This really is quite bothersome and actually quite frightening to me if this is going on in other fields of health. As an educator, I have volunteered several times at our local branch to provide some basic hearing health care education, but at no time has this education opportunity been taken.

If a second quote is requested, the branch then cannot defend their decision with any evidence. As a health care provider who believes in evidence-based practice and patient-centred practice, which appears to be paramount in our province, this is quite frustrating.

Finally, this mandate by the Ontario Disability Support Program is not being implemented across branches or even within branches in any form of consistency. One patient can have no requirement for a second quote and the very next patient with very similar recommendations will require a second quote, which is very frustrating for the patients.

As an example, I recently had a patient who has his counsellor, family physician, pharmacist and audiologist all working together in the same building and working together for months to facilitate his progress back into the world of employment. ODSP has now requested a second quote from another provider, whom he is completely unfamiliar with and he feels uncomfortable with and they're unfamiliar with his background. The patient cannot understand why he cannot choose who provides his care. Additionally, he only lives three blocks from his audiologist.

With reference to Ontario Works, they have now asked the province to provide funding for only one hearing aid. To put this in a simple analogy, this would be like asking to have only one lens for your glasses. The anatomy of the ear relies on binaural stimulation and bilateral stimulation that localize and to be able to function in background noise and to follow a bunch of other things that I could get into in great detail.

This is the one that probably bothers me the most from an emotional side and from a parent of three: Ontario Works has stopped paying for children's hearing tests. Hearing is a vital sense for speech and language development, social development and future socio-economic status. Research will suggest that the economic loss can be in the order of tens of thousands annually, if a hearing loss is left untreated.

The choice appears to fly in the face of our universal infant hearing and screening program that was adopted in 2003. If hearing is important, then I think the province should maybe recognize that in all aspects for all Ontarians.

My hope is that ODSP and OW will consult with audiologists, which I do not believe has been done to this point, or, I should say, prior to the implementation of this new mandate, to ensure the best support is provided for those who require hearing services and to hopefully cease their current policies and ensure fairness is provided to all Ontarians.

That's all I have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about nine minutes left, so it will be three minutes per party. I think we start with the opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. You've really given us a good view of what's going on. Did you say that Ontario Works has started to only fund one hearing aid?

Mr. Calvin Staples: Yes. It's never been formally presented to us, but then, when the cases are presented, this is the message that we receive back. There has been very little communication from the ministry that governs

Ontario Works to the health care providers. It seems to come down as kind of a trickle-down effect through the branches, and I tend to feel sorry for the people at the branch and the caseworkers making the decision, because they're just following a mandate that they clearly don't understand.

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Mrs. Christine Elliott: I suppose, because it's funded through MCSS—that's where it would come from, through Ontario Works—then it wouldn't fall under the mandate of the LHIN because that's the Ministry of Health. Is that correct?

Mr. Calvin Staples: I wouldn't know. I'm assuming that you may know.

Mrs. Christine Elliott: I'm assuming that too, but clearly it's something that needs to be addressed. We'll certainly take it back with us, even though the mandate of this committee—it's not something we can do anything about, but I really thank you for bringing this to our attention.

Mr. Calvin Staples: No problem.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Armstrong?

Ms. Teresa J. Armstrong: Thank you very much for presenting that perspective.

I had someone contact our office who was a hearing agency, and they were kind of confused about the two-quote process that they now selectively ask patients to go through. One of the comments, though, that they had made was that even though a patient gets a second quote, if it's a lower quote than what they were given, it's not necessarily the quote that's chosen.

Mr. Calvin Staples: Anecdotally, I can say that that's not happening. Anecdotally, it has almost become a bit of a race to the bottom. To speak relatively candidly, it's also a system that has created dealings going on that I won't participate in. As much as we think all things are created equal, they're not.

They're not looking at the actual care of the patient that needs to be put in place. Hearing health care—the device is the device, but how you manage that device and how you present that device and the training that's provided is not even acknowledged. So to provide just a quote on a device—and sometimes the devices aren't even the same.

Ms. Teresa J. Armstrong: Is there a purpose to the second quote?

Mr. Calvin Staples: The second quote is to ensure that pricing is accounted for, and I respect it because I think there were some things that were going on that shouldn't be going on in our industry. That being said, it has been achieved.

Ms. Teresa J. Armstrong: One of the things that they were confused about, especially with the ODSP—they wanted to know if there was a directive from ODSP specifically asking for a second quote, because it wasn't a standard for every patient. We looked into that. Apparently there wasn't a directive. Any knowledge on that?

Mr. Calvin Staples: Our understanding is that there has been some communication with—I could look up the

name, but I can't remember it. Anytime I've dealt with a branch worker, they've vocally told me that they need to find the cheapest cost.

Ms. Teresa J. Armstrong: Apparently that wasn't the situation with—

Mr. Calvin Staples: No. It's not being implemented across the province, across branches similarly, so it's very inconsistent. It definitely appears to be that certain—based on some of the discussions we've had earlier today, especially the last one, different places are implementing this differently. What we've asked for is to put together some sort of funding schedule, and use audiology as a consulting basis to ensure that, "Yes, this hearing aid meets the needs of the patient and we probably don't need to spend this amount of money."

Ms. Teresa J. Armstrong: And one last thing—

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Mr. Staples, for coming by. Even though perhaps this is a little outside the scope of what we're looking at, you've presented us with some interesting facts. I just wanted to clarify: When you say that approximately one third of Americans between ages 65 and 74 and nearly half of those over age 75 have hearing loss, is the implication that they actually require hearing aids?

Mr. Calvin Staples: That's untreated hearing loss that requires it, yes. And those stats can range up to—that can be higher. That's from the American speech and hearing association. I've seen 40%; I've seen adults at 80% and up to the 90% range.

Ms. Helena Jaczek: Okay, good. I'm going to present that to my husband very, very shortly, as he falls in there.

The other question I had: When you were talking about this move to only fund unilaterally, one side, are you saying that previously both sides were funded?

Mr. Calvin Staples: Yes.

Ms. Helena Jaczek: So this is definitely a change?

Mr. Calvin Staples: A change, yes.

Ms. Helena Jaczek: Okay. That's useful to know, and I feel sure we will need to find out why. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

GUELPH WELLINGTON HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presenter is the Guelph Wellington Health Coalition: Magee McGuire, chair. Welcome. You will have 15 minutes to make your presentation. You can use any or all of it for that presentation. Any time left over, we'll have questions and comments from the committee. If there's less than four minutes left over, it will only be one party doing it; if it's more than four minutes, all three parties will have their share.

With that, the time right now is all yours.

Ms. Magee McGuire: The Guelph Wellington Health Coalition is pleased to present to you this morning. We

want to demonstrate that health, education and social determinants of health need to be addressed as a matrix problem for essential good health. Therefore, we will speak to those issues conjointly, with health care as the pivotal focus.

Our summary statement will be to ask that the money goes where it is needed the most. Statistics demonstrate that 20% to 30% of the population uses 70% to 80% of the money. Therefore, why not focus on that 20% to 30%?

As an RN with 37 years of experience in both family clinic and hospital venues for all the areas of the hospital, I believe that they have intrinsic worth. We hope you will agree that one priority is home care management, as our stories unfold.

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We also request that you withdraw funding of any service formerly done in-hospital and now done by private companies. The subsidy for this has been costly. What start-up business has ever been guaranteed income, clientele and business incentives by the bank? There was no foresight here, and if there was, then there is a hidden agenda. Takeovers or price undercutting of service is a common business expansion strategy that we'll see. This can eventually lead to speculation, non-inclusiveness, member policies and higher costs, all without transparency.

We request that you consider planning a not-for-profit model within the hospital by using the empty operating rooms and local physicians to do the small surgeries that might enhance the envelope of the hospital, while being transparent and evaluated. The law permits you to do this.

We also ask that any additional unnecessary services now being offered persuasively by cataract clinics in addition to cataract removal be stopped. Patients must be advised that this procedure is unnecessary unless deemed essential by their family physician, who can be monitored for validation. These clinics need to pay the government for the subsidized benefit of referral and advertising. There is no competition in this business. Is that development of business the mandate of medicare?

Let's review the social determinants of health. We cannot be healthy unless we have affordable housing, balanced nutrition, education and safe environments. Healthy Canadians make a healthy country. This needs to be a message delivered and understood by government and facilitated for the citizen.

Limiting the number of glucose monitor strips is a step backwards. Does this ministry now diagnose and treat? This decision needed input from the College of Physicians and Surgeons and their members.

Decades of studies have proven the inferior health status of disadvantaged persons. In an inner-city study done on new moms, low income was connected with three to five adverse conditions: birth outcomes, postpartum depression, serious abuse, frequent gestational hospitalization and frequent episodes of stress. New moms had more multiple health problems as a result. I

encourage you to support the case coordination that is about to be employed in the new mental health strategy in Guelph Wellington, which links to other services as needed to this situation.

Time and again, we have heard about the massive negative effect that the aging population will have on the cost of health care. This leaves most people worried about what care they'll receive as they get older. This is a myth, and it is your responsibility to dispel this myth. Annual profiles within information from the Evidence Network compared 1993 to 2013 and found that the cost for every age has grown. Costs are incurred from treatments, diagnostic tests and doctors, not to speak of pharmaceuticals. CIHI figures show that the aging population will drive the cost up only 1%, and Stats Canada has suggested that only one in 100 persons will require long-term care. So please stop the rhetoric and tell the truth.

For dying patients, barriers to a dignified death have been patient-referenced. Patients feel they are being patronized because of age, and are ill advised about advance care planning. Only 4% of patient preferences were documented by doctors, and a major complaint was that the doctors were not explaining the meaning or the intent of the legal document for advance care planning. This results in treatments that patients neither want nor need. It also permits the dysfunctional family to squabble over what to do at such a stressful time. Do you want to spend your money on poor strategies or on giving a voice to patients, their needs and their responsibility? When their pension papers arrive, they could receive advance care packages to complete as part of the process. Nurse specialists can do this work.

CCAC elderly clients, especially from rural areas, are paying up to \$160 out of their monthly government pension for a taxi to see a specialist four hours away in a centre of excellence. There is no assistance even when they have a walker. Taxi drivers do not add this service to their job. Is this what you call value for health tax dollars?

Private clinics are soon to be embraced by the Ministry of Health with open arms. What are you going to invest in? Will there be tax breaks and incentives for the building of the new \$45-million for-profit medical centre in the Hanlon business park in Guelph? Will you continue to subsidize the medical doctor who receives tax-deductible office expenses and who practises there in both family practice and a for-profit service like acupuncture and vein salination, losing precious patient hours for the publicly funded system? We request that you claw back for doctors practising this way to create a more responsible, accountable and ethical payment model.

The general hospital in Guelph has lost its outpatient lab, its mother-baby clinic that was installed because of a baby death inquest recommendation, a preventive respiratory and cardiac clinic, a short-term rehab centre, its pacemaker clinic, its diabetic education clinic and a medical and surgical ward, all this after a strategic amalgamation of services between two hospitals to give full

central services and built to suit. It will soon be obsolete and retain only emergency care patients. However, "emergency" and "essential" are not synonymous.

Did a 0% increase to the Guelph General Hospital give it any extra money to upgrade its pacemaker service or restore important clinics? Did it stabilize its budget? No. Did the solution satisfy the needs expressed? No. Solutions being offered are not being integrated for prevention. That is the unfruitful mantra of the ministry. Even our central lab was closed in the black. Labs popped up to be bought and sold. Unfortunately, only those with cash or credit can have many deleted tests done. The result: People without means do not get the test, and the doctors' hands are tied for diagnosis.

About the pacemaker clinic: In July 2013, the Guelph General Hospital announced the closure of the pacemaker clinic to satisfy its promise to the LHIN that it would integrate this service with the clinic at St. Mary's. It served approximately 750 patients. The reasons changed from day to day. Three patient advocates took on the responsibility of approaching the hospital for a solution to the transport problem. They were told that the VON would provide a return trip for any person who could not get transportation for the cost of \$24 a trip. The VON, which was never consulted at all, learned of this plan through the media. The GGH stated it would pay for any applicant who could not afford it.

In October, St. Mary's announced a new collaborative plan for remote monitoring of pacemaker patients at the Evergreen centre, but only of those with Medtronic pacemakers. The Honourable Liz Sandals, MPP, suggested having travel teams come to Guelph to offer this service. The advocates have suggested that this new idea be upgraded to a traveling remote facility that can serve all of LHIN 3. Stakeholder involvement is critical to best decisions. Indeed, this may even have been a solution for St. Mary's hospital, which has invested in expensive technology for a cardiac program, which in all essence will suffer some decline as some new technologies come forth.

Community-centred health teams or the family health team models are not always available 24/7. Doctors and patients have told us that many answering machines still direct patients to the emergency centre of the hospital or are not responded to. This service needs evaluation and oversight.

Do the increased payments to physicians guarantee better outcomes? The wait lines haven't decreased, yet the average number of visits to both family doctors and specialists has stagnated or dropped by 5% to 7%. Doctors are also choosing to work less to improve their personal life quality, especially the growing number of female doctors. We agree with the Evidence Network that there is a failure in policy. Shall we continue to increase incomes and get less care? There needs to be better oversight.

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In northern and rural areas, there is a great need for specialists, but one in six graduate specialists cannot find

enough work. Regional distribution is an issue. Wait times in remote and northern areas are twice as long as here; yet the solution for the north cannot be a degradation of service in south and central Ontario, where wait lines are increasing.

Then one wonders at the Guelph “Schlegel Villages” plan for a family practice on-site of their long-term-care home, and a college ed centre, without any due diligence by management or the doctors involved as to whether the site was appropriate for a family practice. Dr. Mercer, chief medical officer of public health, would have questioned this oversight. The only concern of the proposal by these private operators was to gain zoning for such an enterprise. This is not good pandemic prevention planning. As for education, nursing programs have already invested in rigorous precautions for students who do their practicum at the bedside of any health care facility.

Call it what you will, but the CCAC was meant to be a hospital without walls. Initially, the government saw it as the ultimate solution for hospitals to gain more beds without expansion and permit patients to go home with essential services, costing less. Sadly, the funding required never transferred with the responsibility.

What really happened over time is a change in following the patient with continuity and a nursing care plan for discharge goals. Did it save the ministry money? Absolutely not. The facts rest in the ministry reports. Family physicians gave up admission privileges and were replaced with an increasingly expensive hospitalist program. The discharge team excludes the family physician, a key consultant. Medical staff who specialize review part of the patient and do not implement holistic principles. The special nurses often underutilize their comprehensive training.

The CCAC RN would assess to accept the patient on home care but was not the provider—usually a private, for-profit administrator who hired staff to do the work. Add to this the bidding process, which took thousands of extra dollars to just process an application instead of using it for front-line work. Most often, the bid went to the lowest bidder for the same or better number of services. If this were accomplished, then why, when their budgets start to run out, usually in the spring, do these agencies cut back the hours of workers and patients? This is not working.

The rhetoric expressed by the recent home care workers’ strike is still the same rhetoric the public has heard from the initiation of the integrated health act in 2006. Is it smart to continue to ignore the failings in this act?

When the Ontario training colleges report from 2004 forecasted a severe shortage in resources by 2017, the strategic operational plan of the LHIN did not reflect this information. Their goals have consistently been to seek efficiencies in the system that had nothing to do with the need being met by an adequate workforce. There were no goals for succession, recruitment, retention, worker satisfaction or governance evaluation. Participating communities of interest initially posited the connection between the hierarchy and the communities, but these were

cancelled without notice to members in favour of hiring a consultant. I observed that the chair was unable to draw out common issues and solutions from the competitive personalities of the navigation COI.

I do want to give you a case scenario for costs. One day in hospital costs approximately \$1,250. Eighteen hours of home care costs approximately \$360 for four weeks. The government pays a long-term-care facility approximately \$1,700 a month per client, and the client loses their pension but gets an allowance. It’s obviously much cheaper to care for a patient at home. So what happened to all the money that was saved?

Also, the truth must be faced in CCACs. Sixty-two cents out of every dollar buys a service from an agency. That is \$72 million out of \$116 million. The Red Cross agency reported a further reduction to paid hourly care of 22 cents.

On the last page, I would like to—I’m skipping a lot of stories that you can read later. The reason for these cuts was stated by Hugh Mackenzie and Richard Shillington, who are economists. They stated that the average cost per annum of service for a client family is \$41,000, which a person without insurance would have to pay themselves. This option is not possible for the 20% who use 80% of the health dollars. The conclusion is that the top 10% of wage earners pay less health taxes than the lower middle class.

I’ve pretty much covered the essence of what I want to say, and I thank you for your time.

The Chair (Mr. Ernie Hardeman): You’ve also pretty much covered the time allotted, but we can assure you that obviously the committee will read the rest of the report that we didn’t have time to include.

Ms. Magee McGuire: That’s fine.

The Chair (Mr. Ernie Hardeman): We thank you very much for making the presentation.

Ms. Magee McGuire: You’re welcome.

GUELPH POLICE SERVICE

The Chair (Mr. Ernie Hardeman): The next presentation is the Guelph Police Service: Bryan M. Larkin, chief of police, sir. Welcome and thank you very much for being here. We appreciate that. You will have 15 minutes to make your presentation. Any time left over will be divided equally among the three parties, unless there are less than four minutes and we’ll just give it to one party.

Mr. Bryan Larkin: Good morning, and thank you so much. I think I’m going to take a page from Chair Seiling and make my comments brief and sort of shift focus a little bit from your previous presentations. I want to thank you for the opportunity. I hope that many of you are sitting here thinking, “What is a police chief doing sitting at a LHIN legislative review standing committee?” Hopefully, you’re thinking that. I want to bring some context as to why, as chief of police, I’m here, and provide some background. I’m an active member of the Ontario Association of Chiefs of Police and the zone 5

director; as well, I sit on the Canadian Association of Chiefs of Police drugs and substance abuse committee.

A couple of years ago, when I was appointed the chief of Guelph, I became intersected with the public health system. I currently sit as a member of the working group on Guelph Health Link as well as Mayor Karen Fairbridge's advisory committee on community health and well-being, which is focused on the social determinants of making change within the city of Guelph, and systems thinking change and collaboration and integration. For the last six years, I've served as chair of the Stonehenge Therapeutic Community, which is a drug residential rehabilitation centre in the city of Guelph that provides long-term care for those seeking rehab. That particular organization is funded about 52% by the Waterloo Wellington LHIN and the other 48% through the Ministry of Community Safety and Correctional Services. So I find myself intersecting with the public health care system.

I want to really speak a little bit and echo the comments of Chair Seiling. Probably three years ago, I would not be sitting here, because I thought that the local health integration network and some of the systems reform that were happening were misaligned and there was a misunderstanding in our community. There were different focuses—not necessarily sure what was happening or where the money was going. But I want to reiterate and I want to reaffirm, from the position I sit in as a community leader and a community builder whose organization intersects daily with the health care system, whether it's supporting and working with agencies that are supported by the LHIN, the Wellington Dufferin public health unit that also serves the city of Guelph, as well as our hospitals, that our police officers are supporting different activities. Whether that's through mental health support, whether it's through child and sexual abuse investigations in our hospitals or working with treatment centres, we intersect consistently. There was some misalignment, but earlier today, we heard from Mr. Lauckner, the CEO, and Ms. Fisk, about the number of successes that are happening. I truly believe that we're blessed in Ontario to have a wonderful health care system. It's great that we're having discussion about improving this. I want to reaffirm my belief that over the last three years, locally, change is afoot. There is discussion about being bold. There's discussion about bold public policy. There's discussion about changing the way that we do business, not only in the health care but also in policing. We're under a significant amount in policing of sustainability, discussions about the economics of policing, and working with the Ministry of Community and Safety and Correctional Services on the future of policing.

One of the challenges is that we're doing this in isolation. We intersect consistently, and I'll speak to that in a little bit. I'll certainly agree that the province and the Ministry of Health is responsible for that 30,000- or 40,000-foot provincial strategy. That large ceiling has required policing supports and provincial and national strategies on many different issues, but there's a localized

function. That localized function is really on the health care system delivered locally by the Waterloo Wellington LHIN.

We deal with unique issues. We deal with the diversity of our neighbourhoods. We deal with the diversity of what's actually transpiring around the demographics of our community. So there's not a cookie-cutter approach across the province—although it also balances the provincial health care strategies, and it brings about the change, and we've seen that. Mr. Lauckner talked about cancer treatment and access to the Grand River cancer centre, hip and knee replacements, wait times in our emergency rooms etc.

Those things are fantastic, but the discussion that we're not having here, or the discussion that we're having in isolation, is around the social determinants of health, the national well-being index on healthy communities. It's about redefining when we use the words "health" and "well-being" in our community. It's not necessarily thinking about hospitals. It's not necessarily thinking about hips, knees and all those different pieces. If we do not focus now on poverty, child obesity, access to food, affordable housing and leisure, then 50 years from now we'll still be dealing with knees and hips and different issues, but we'll also be dealing with crime and social and public order issues. We know that people commit crimes to feed themselves, to find housing. They're all intersecting each other.

So I want to reaffirm a position where we're all intersecting. The impact on our health care system, our education, our family child welfare, public health, our community safety—all of these different agencies all intersect with the health care system, but we're having discussions on reform in isolation.

One of the things afoot in Waterloo Wellington—and I want to credit the leadership of Mr. Lauckner and the board chair, Ms. Fisk—is that three years ago, we started having the dialogue collaboratively, looking at the collective impact that we can have on our communities about change, about using the ratepayers' dollars in a more efficient, more effective opportunity. It's about capacity. We have capacity in our respective systems. We know we can find efficiencies within our respective systems, but if we don't have the dialogue collectively, then the capacity keeps getting used and the escalation of costs continue to increase. With the Waterloo Wellington LHIN budget just on the verge of \$1 billion, we recognize that we have to do business differently.

I want to use an example in Guelph: our "Million-Dollar Murray" in Guelph, with 500 calls last year to one address for the police service, equating to over \$150,000 of police resources. That doesn't include our health care system. It doesn't include our emergency medical services system, our public health intervention, our mental health association intervention. As the chief, I'm not necessarily proud that we went there 500 times, because if you were to look at that, we're failing the client. We're actually doing a disservice to the individual who needs the service most. Yet there are many success stories, and we're doing many things right.

As we move forward, we talk about human service delivery, and we talk about changing the process and really pushing and urging this legislative committee to look at inter-ministerial discussions, dialogue.

We look at some experiences out of the province of Saskatchewan, where all the major players—emergency services, police, education, the health care sector—are now sitting at the same table discussing budget allocation, discussing community priorities, discussing provincial and national strategies.

I certainly want to encourage the legislative committee to look at the capacity of localized LHINs. Again, three years ago, it was probably a different story. I think there has been some great success, and I'm speaking, obviously, as a community leader and community builder within Waterloo Wellington. That system change is afoot. But I want to reiterate that if we don't look at a mandate that includes prevention, promotion and actually changing the way we do business and redefining our discussion around health and well-being, our future leaders, 50 years from now, will likely be having a similar discussion—the whole repetition process here. When we look at the impact, from a policing perspective, of the mental health system and the use of illicit and other social addictions—drugs, gambling—on policing, it then impacts our mental health system, which impacts our health care system. Essentially, we're in a cycle.

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It's time for change, and I'm very pleased to say that Waterloo Wellington has certainly come to the table to look at change and integration change.

So I want to reaffirm the localized approach for the LHIN delivery of services, with a balanced approach to a provincial strategy, which hopefully ties to a national strategy, but also encourage that we expand the mandate around social determinants, the national index of well-being.

I'll simply leave this item for discussion: Healthy communities are safe communities and safe communities are healthy communities.

I want to thank you for the opportunity to speak to the committee.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two minutes for each caucus, so we'll start with the third party. Ms. Armstrong?

Ms. Teresa J. Armstrong: You're participating, obviously, with the local LHINs, and the mental health piece is the one that you're kind of focusing on and how that can benefit people in the area. So what kind of contributions or what kind of meetings have you had? Do you see that making a difference? Is there some collaboration, that they're taking your ideas to try to have a formation of some better system?

Mr. Bryan Larkin: I think a step forward is actually having access to the CEO of the LHIN, having discussions and having them meet with not only me but my colleague in Waterloo region and actually discussing where we can move this, bringing all the players to the table to look at collaboration.

It's no different than on the drug piece. We're leading two separate—a Waterloo drug strategy and a Wellington drug strategy, so they respond to respective needs, but previously the attempt to move that forward was not successful, and now we're actually getting traction where we're looking at: This is important. How do we find funding? How do we look at different forms, including harm reduction and different pieces, to make this work?

Because there's this other impact on the judicial system. We're sending people through the judicial system who ought not be in the judicial system; they need to be in the health system.

Ms. Teresa J. Armstrong: We had a presentation earlier about—

Mr. Bryan Larkin: That's right.

Ms. Teresa J. Armstrong: —a very sad and unfortunate story.

Do you know of any other LHINs in the regions that are actually consulting with police chiefs? Do you know if that's something that's happening elsewhere, or are you the first?

Mr. Bryan Larkin: I'm not familiar with that, although we're trying to have a discussion at the provincial level from an Ontario perspective with our minister, Madame Meilleur, around making this an inter-ministerial discussion about systems change and systems reform.

Ms. Teresa J. Armstrong: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Colle?

Mr. Mike Colle: Anyway, I'm most impressed. This is really unprecedented. Being on various committees on health and everything, to have a member of the police force really go above and beyond the norm, let's say—that's not to say that other police officers don't do this; I know Chief Blair in Toronto does this quite well, but I think the people of Guelph and this area should be very, very proud to have a leader like you there who goes to the root causes and talks about the social determinants of health and about prevention, and looks at the whole picture.

To be involved with LHINs and the health care providers—I think that this kind of leadership coming from, let's say, not the usual partners in health care really strikes a chord. It certainly has with me, and I just want to encourage you to keep doing what you're doing. I think you're doing something that's really to be admired, and I just want to say, keep doing it.

This is real leadership. As I said, I'm most impressed, and I've been doing this for 20 years. I don't usually get this impressed, so keep doing it, okay?

Mr. Bryan Larkin: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms.—

Mrs. Jane McKenna: McKenna.

Laughter.

Interjection: Ms. Sandals, actually.

The Chair (Mr. Ernie Hardeman): I didn't know which one it was. Ms. McKenna?

Mrs. Jane McKenna: Thank you so much for being here today. It was very inspirational listening to you. I think the thing I loved the most that you said was—I was a critic for children and youth, and I've done my white paper on that, and I just realized how many systemic problems we actually have.

For an example, 70% of the kids in the crown end up on the street. Building more places for them to go is a band-aid; it's not actually the prevention of helping the person. The amount of taxpayers' money that we actually waste because we don't help these people from beginning to end is in the millions of dollars per person.

I think my one question I want to ask you is, at what point did you realize—I know you said three years ago that you needed to look at prevention. Not everybody loves prevention, because it's not a fast dollar back, so people like to just do the band-aid—I hate to use the word “band-aid”; I apologize—but the fast fix. It'll be a hard sell in that sense, but at what point did you realize that you needed to do it?

Mr. Bryan Larkin: Well, probably at multiple points. Prior to becoming the chief in Guelph, I spent over 20 years in Waterloo region as a police officer, and I think that the region of Waterloo was well known for social and community development.

Former Chief Gravill took a very different approach, largely based on some different processes around our Mennonite culture and victim-offender reconciliation and different pieces. We started to focus that way, but clearly, when I started to look at profit and loss and finance sheets as a deputy chief and then a chief, it's not sustainable. You start examining the cost of individuals through our health care system and then we start looking at examining the amount of time we spend in hospitals with mental health patients, but then also intersecting with family and children's services. We could put a family and children's services worker in a police car and go call-to-call with a mental health worker and probably provide better service and totally reform our service—and maybe throw a public health nurse in there—and actually provide a total systems approach to serving our community, which is non-traditional and which worries people. I think that this was the discussion I had internally and with some of our collaborators in Guelph and Wellington. As a chief and as other executive directors or leaders of agencies, you fear loss of control. But if we don't make change today—so it's come through that.

Mrs. Jane McKenna: Great.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Chief. We appreciate you being here and bringing your view forward.

INDEPENDENT LIVING CENTRE OF WATERLOO REGION

The Chair (Mr. Ernie Hardeman): Our next presentation is Independent Living Centre of Waterloo Region: Brenda Elliot, executive director.

Interjection.

Ms. Brenda Elliot: Good morning.

The Chair (Mr. Ernie Hardeman): The Clerk just informed me I should have told the committee that the one just ahead of you cancelled, and I said it becomes quite obvious when we introduce this one that the one that's in between isn't here.

Thank you very much for coming forward and being here and sharing your views with us today. You will have 15 minutes to make your presentation. If you don't use it all, if you have less than four minutes left, we'll have one caucus ask questions, and if it's more than four minutes, we'll divide it equally between the three caucuses. With that, right now, the 15 minutes is yours.

Ms. Brenda Elliot: Great. Thank you so much for allowing me to present. As stated, my name is Brenda Elliot; I am the executive director for the Independent Living Centre of Waterloo Region. I am a recent incumbent to that role; I've only been in the role for about seven months now, and I'm new to the Waterloo Wellington area. I still reside in London, but I'm getting quite familiar with Waterloo Wellington.

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The Independent Living Centre of Waterloo Region is the largest not-for-profit organization providing attendant services and assisted living for individuals with a physical disability in southwestern Ontario. ILC was the first independent living centre in Canada and is proud to be a part of the independent living movement for over 30 years. ILC consists of attendant services and an access and awareness side that provides individuals with a disability skills to self-advocate. We also offer education and awareness for the general public, AODA and barrier-free training as well as our youth in transition program. We provide services to over 270 individuals and employ a workforce of approximately 250 people and over 50 volunteers, the vast majority of this workforce being comprised of personal support workers. ILCWR is a member of the Ontario Community Support Association. As an organization, ILCWR is well positioned to contribute to the current discussion on the local health integration networks.

Ninety per cent of ILC's funding is received from the Waterloo Wellington LHIN. This funding is for outreach attendant services and for our three assisted-living sites. In our three assisted-living sites, we have 12 individuals at each site that we support, with a variety of physical assistance required.

The relationship with the LHIN is based on open information-sharing and timely communication. Our LHIN has worked consistently to engage their key stakeholders in collaboration and identification of best practices. The LHIN has engaged the community support services network in examining gaps in the system and a structure to support individuals in the community. They have demonstrated a commitment to the community and to individuals with a disability. They have recently invested over \$400,000 in attendant services for individuals with a disability. This is the first significant investment in over four years, and it took a wait-list that resided in this

region that was well over 200 individuals down to under 70. That's a significant closing of the gap.

They have also made a one-time funding commitment for the purpose of creating more accessible housing for individuals with a disability. The LHIN has demonstrated that they are in the position to make informed decisions on health care as they act at the local level.

While I'm somewhat reading from the script, I will digress the odd time to interject a key point.

Accessible housing is an incredible barrier for individuals. We have individuals on our wait-list for assisted living that are currently residing in long-term care or in alternative-level-of-care beds in the hospital as a result of not having access to accessible housing. These are individuals who are 30, 35, 40 years old who are in long-term care who would be better situated in the community—better supported, able to maintain an active life and the life that they would like to choose to live.

While ILCWR acknowledges a positive relationship with the Waterloo Wellington LHIN, that's not to say that there are not areas that require improvement. With any relationship, there are always things that can be better. I have teenagers, so I'm well versed at saying that on a daily basis.

In the area of disability supports, we continue to be co-opted with seniors. I believe this happens across the LHINs, that when they're comparing services and how services are delivered and the common denominators, individuals with disabilities are very often lumped in with seniors. While the consumers that we support will age, they're not seniors. The care they require is very different from a senior care model. It creates discrepancies in care levels as seniors' needs are significantly different than those of individuals with a disability. While the Waterloo Wellington LHIN has acknowledged that this is an issue, there's been little done yet to make these corrections when it comes to reporting service and validating service needs.

In the funding corridor there exists a continual shortfall to community support services. We have not had an increase to our base funding in over six years. Under the LHIN funding mandate, budgets with providers do not properly take into account administrative costs. We are tasked with keeping our budget to a zero increase. As a result, we are continuing to serve an ever-growing consumer base with no increase to our base budgets.

As our fixed costs of rent, heat and hydro continue to rise, we struggle to meet our financial commitments. Our employees receive minimum pay equity increases, and we place training for staff at a basic level.

I was quite shocked when I came on board with ILC to find out that we won't reach pay equity until 2025. What shocked me even more is, we are really not alone. The fact that we can give a 1% to a 1.3% increase a year is pretty normal for community support services, and it's a real struggle. It's a real struggle on health human resources. Health human resources remain a key risk for the community support sector. While many organizations continue to lag behind in reaching pay equity, the

institutions such as long-term-care homes and hospitals continue to pull further away in pay for personal support workers.

ILCWR is on par with other not-for-profit organizations but falls significantly behind institutions. The average pay for a PSW at ILC is \$16 an hour. In an institution, this same PSW will start at a rate of \$21 to \$22 per hour. This creates a revolving door of CSS agencies training PSWs and these PSWs then leaving for institutions once they have experience. So we provide them with the skill set. We provide them with the training. We take them on when they're fresh and young and new because we need the resources, and within three months to six months, a lot of times they're leaving for a place that can offer them permanent full-time. Even with us offering benefits at 25 hours, we just simply cannot maintain the hourly rate that the other organizations do. And I come from a long-term background, so I'm well versed in what they pay and their collective agreements. I wish we could get there but right now we're not there.

To meet the future demand for community services, the Waterloo Wellington LHIN needs to invest in community support services and allow us to close the gap in health human resources.

It is well identified that supporting individuals in the community promotes better health outcomes while reducing the strain on ALC beds and long-term care. Further, community support organizations provide care in a community that would otherwise be done by nurses. This results in a saving of approximately \$30 an hour and provides continuity of care for an individual being served. For example, it's \$26.50 an hour for a PSW but \$58 to \$64 an hour for a nurse. An average cost for one day of assisted living is under \$200; the costs for one day in an ALC bed are currently recorded at over \$1,000.

ILCWR PSWs provide services from housekeeping and meal preparation to catheter and trach care to personal care. A lot of our PSWs do what are called delegated tasks. They're trained by a regulated health professional, and then our PSWs do this care. Where a CCAC would send a nurse out to do catheter or trach care, our PSWs are trained and are able to support this, so our individuals are supported with one person, seamless care, somebody who is well adapted to qualify any changes in health status and report it to individuals.

As the demands for home supports increase, it's critical that we receive an increase to our base funding. Without this increase, our wait-lists will continue to grow and organizations will continue to struggle to meet pay equity demands without closing the gap to ensure a living wage for our employees. I know that "living wage" is thrown out there a lot, with the minimum wage now going up to \$11; \$16 an hour might seem great, but to try to provide and work two to three part-time jobs making \$16 an hour to make ends meet leaves little time for quality of family and quality of life.

The average wait-list for an assisted-living bed in Waterloo Wellington is nine years, and that hasn't changed. We have individuals who are sitting on there

for nine years. They end up in long-term care at the end of nine years. They've just given up and they end up staying there because it's what they're used to. It's not what they deserve or the value of life they should be able to maintain, but it's what they're forced to take.

Another identified gap is in primary care for individuals with a disability. A recent survey conducted by ILCWR shows that over 60% of our consumers have not had a complete physical exam since they were a teenager. These are individuals who are 45 to 65 who haven't had a physical since they were a teenager. They advise that while they can access care for basics such as vaccines and a general exam—a cough-cold kind of symptom—that having a pap smear, mammogram or prostate exam does not happen. The reason given is that while clinics are accessible—so a wheelchair can get in the door, someone with a visual-acuity issue can get in the door or with a hearing issue can get in the door—once they're in there, in the exam room, the exam tables are not accessible; there are no lifts or supports to transfer an individual to the table. A lot of times you'll find that while a building will say it's accessible, it's truly not. Either the font is not acceptable for visual reasons, or the tables aren't accessible for somebody, so unless they have somebody going with them to do that transfer, they can't access that sort of care. Somebody with a hearing impairment—there is not always somebody there who can assist with those sorts of little things that make primary care essential. A lot of our consumers just simply choose not to go: "Why bother? They're not going to listen to me." They have to go to the hospital for a lot of their care, and they just give up trying.

We would ask that, moving forward, the LHIN critically examine any increase provided to organizations and institutions to ensure that the dollars are spent on quality care. We acknowledge the long-term care has long struggled to balance their budgets. However, we would ask how they qualified the need for this increase that they recently received—I believe it was 4%—when they continue to pay dividends to stockholders and bonuses to their executives. When the not-for-profit world has to continue to balance our budgets, and stockholders are being paid dividends and bonuses—it simply does not merit an increase to me.

ILCWR firmly believes that the key priority for our health care system is to continue the move toward community services. Individuals deserve the right to stay in their homes and maintain their quality of life. The LHINs are best suited to do this as they are closer to the community. A better effort is required to coordinate the functions between the LHINs and CCACs. There remains duplication in services provided and in administrative roles. While the LHINs have made great efforts towards consistency, this must remain an ongoing process.

The LHINs have afforded organizations like ILCWR to be part of discussions regarding health care that we were not formally involved in in the past. This move has allowed community support agencies to review services delivered and collaborate to ensure seamless delivery in

supports. Community support service organizations in Waterloo Wellington now use a system called Caredove. This program allows any organization to make a referral for a consumer, creating an "any door is the right door" opportunity. The LHINs' continual review of services has resulted in consistency to care provided, costs in certain areas have been validated, and collaboration has allowed organizations to leverage learning and training for continued success.

In summary, while the LHINs face their challenges, ILCWR believes that they are well suited to meet the community's needs. They are local, and as such have the ability to be at the grassroots level and be reactive to the ever-changing health care needs of the community. Devolving the LHINs would not immediately improve the health care system and could negatively impact the delivery of home and community care.

Any review of the current health care delivery system needs to take into account the challenges of maintaining a healthy population while managing our health care budget.

ILCWR is committed to working with the LHIN and government in delivering the highest-quality health care to our community. We look forward to the future and greater investments to health care in our community. Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have an opportunity for one question. I think it goes to the third party: Ms. Armstrong or Ms. Fife.

Ms. Teresa J. Armstrong: No. If you would like to add anything else to your presentation, I'm happy to hear the feedback that you have, or—take that time.

Ms. Brenda Elliot: Well, Waterloo Wellington is not the only LHIN that is having the challenges when it comes to accessibility. It's not just for individuals with a physical disability; it's for anybody with any sort of disability. I think that it's been a long time since there has been a focus on that. The government has recently released a lot of money towards direct funding. That's excellent. A lot of those resources will stay in Toronto because their wait-list is the longest.

So when you're looking at resources and you're looking at the commitment, I think we need to start separating out groups and understanding that the service needs required for individuals are different. Our consumers aren't ill. A lot of the conception is that somebody with a physical disability is ill. They're not ill. They become ill because they lack the opportunity to access things like primary care and the basic community supports that a lot of us can just take for granted and walk out and go and get.

I think the LHINs have done a great job. Just in the last four months, there has been a significant improvement in this open communication, in getting the parties to sit down and collaborate, looking at best practices and making us examine exactly how we're spending our money and where we're spending our money. I think more of that needs to be done.

Coming from a long-term-care background—I know my compatriots will be upset with me for saying this—when you're getting a bonus on a yearly basis and then laying off PSWs on the front line, where are we putting the value? To me, that's not the value. I made the choice to exit long-term care because morally and ethically, I couldn't be there anymore.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation and your comments. That does conclude the 15 minutes. Well done.

That was our last presenter, so we will now recess and resume in London at 2:30. It's going to be healthy eating, because I'm sure it has been stored in this room. There's a boxed lunch on the way out. It's been kept cool all morning.

Thank you all very much for having suffered through this morning. We look forward—from here we will be going further west. We will be going through Oxford county, the centre of the world, the heart of the universe. I'm sure by the time we get to London, it will be warm.

The committee recessed from 1203 to 1431 and resumed in the Queen Victoria Room, Hilton London Hotel, London.

The Chair (Mr. Ernie Hardeman): Good afternoon. Welcome to the meeting of the social policy committee. We're here this afternoon to do public hearings on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We've been travelling the province, and we're happy to be here in London, in the South West LHIN area. We welcome everybody who's participating here.

PARTICIPATION HOUSE SUPPORT SERVICES—LONDON AND AREA

The Chair (Mr. Ernie Hardeman): Our first delegation this afternoon is Participation House Support Services: Brian Dunne, executive director. Have a seat at the end of the table. Thank you very much for being here to participate this afternoon. You will have 15 minutes for your presentation. You can use all or any part of that for your presentation. Any time that's left will be used for questions and comments from the committee. If there's less than four minutes left, it will go to one caucus; if there's more than four minutes, we'll divide it evenly for the three caucuses to all have an opportunity to put forward a question to you. With that, the clock starts now, and the next 15 minutes are yours.

Mr. Brian Dunne: Thank you, Mr. Chair and honourable members of the Standing Committee on Social Policy. Good afternoon. My name is Brian Dunne. I am the executive director of Participation House Support Services—London and Area, a multi-system service partner organization providing services and supports to people with significant physical and/or developmental disabilities, including those who are medically fragile and ventilator-dependent.

The organization is 25 years old and currently operates 53 locations in the South West LHIN. We provide those

supports and services in partnership and collaboration with hospitals and other community organizations and services.

This presentation is informed by our experience working with the South West LHIN and reflects our mission as a community organization. Our mission is as follows: Participation House Support Services supports individuals with developmental disabilities and/or complex physical needs to live in their own homes, participate in the community and enjoy life with family and friends.

We support people in the community in a flexible way that meets their unique needs and contributes to their role as active, valued and included members of this community. This approach is in keeping with a progressive, modern health care system that keeps individuals healthy and connected in their homes and communities, not sick and alone in institutions. We know from international studies that an integrated health care system that is locally derived and driven results in the best solutions when it comes to increasing efficiency and effectiveness of care delivery for vulnerable populations. This includes people with disabilities, who represent the largest minority group in our society.

The Local Health System Integration Act gives responsibility to the LHINs to plan and set priorities at the local level with input from all local stakeholders. This is a very important and effective principle that should never be lost.

Each LHIN has unique geography and historic variability, which reflects the diversity of Ontario and presents unique challenges. The South West LHIN has a large and extensive rural geography. Local planning and priority-setting is the best approach to addressing these unique challenges, as well as province-wide needs.

As a service provider, the LHIN has given organizations like Participation House an opportunity to be included at tables where we were not invited in the past. This is important if we are to share a vision of health care and for best practices. Because Participation House is funded by both the Ministry of Health and Long-Term Care, through the South West LHIN, and the Ministry of Community and Social Services, we see the need to enhance the seamless integration of planning and care delivery between all organizations within the health and supportive care sectors, and this should include housing and transportation.

The LHINs can further build on their leadership role by enhancing the seamless delivery of care across the region. This is especially important for initiatives targeting populations with specialized care needs who are in the top 1%, 5% or 10% of the highest-cost users in the health care system. Many of these individuals are also extensive users of support care services.

Why is local planning and priority-setting so important? I want to tell you about one person whose life has been changed, and about a locally developed partnership that is creating a difference for persons with chronic mechanical ventilation locally and is becoming a regional model for support for this population.

Devon is 18 years old and lived at home with his mom. Devon has Lennox-Gastaut syndrome, which means, in addition to numerous physical challenges, he has uncontrolled seizures. He has a vegal nerve stimulator implanted in his chest. He has an ostomy bag and a GJ tube. He uses a wheelchair. He requires constant, total support for everything, all aspects of personal care, and can never be left alone.

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In April 2013, the day Devon turned 18, he was admitted to hospital. He was very sick, and his already significant care needs increased. With the changes in his health, the loss of support from children's services and the fact that he was bigger than his mom—she had to face the heartbreaking reality that she simply could not care for him at home any longer. She is a single parent; her husband had died of cancer a few years previously.

Even though Devon's health was stable within two months, he remained in hospital for six and a half months while the system struggled with where he could go. He needed 24-hour care in a place that could be suitable for an 18-year-old man with his special needs. The only option seemed to be a long-term-care facility. Devon's mom was very clear this was not appropriate for him, and everyone agreed, but there didn't seem to be an alternative solution. He was 18 years old and he needed one-to-one support several times throughout the day, eight hours a day minimum—support in eating, bathing, changing, all of those support needs.

Then, as she calls it, a miracle happened, and she heard that Devon would be transferred from the hospital to Participation House Support Services where he could receive the 24-hour support he required, funded by the South West LHIN. This was the collaborative work of Participation House, the community care access centre, Access to Care and the local health integration network. As of October 2013, Devon lives with three peers in a fully accessible home, where staff have been trained to meet his needs. He is healthy, happy and thriving, and his mother is extremely grateful for this outcome.

The chronic mechanical ventilation project, sponsored through the South West LHIN, is part of a partnership that was developed to bring people living with chronic mechanical ventilation out of intensive care and back to the community. People who were in intensive care for over nine months are able to return to the community. This solution was locally created in partnership with London Health Sciences Centre, St. Joseph's, Parkwood Hospital, the community care access centre and Participation House Support Services, and we are now developing a regional integrated strategy for this population.

By providing community-based supports and services that are planned and designed locally, in consultation with all stakeholders, including those that are directly affected by them, it means people can stay in their own homes longer and be full, participating members of their communities. This reduces costs to the health care system by keeping people safe, healthy and at home, where I

believe we all want to be as we face the aging process or encounter an event that permanently changes our health status.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes left, so we will start the questions in rotation: Ms. Jaczek, from the government side.

Ms. Helena Jaczek: Thank you, Chair. Thank you so much, Mr. Dunne, for coming here today. I'm very familiar with Participation House in my riding in Markham and the wonderful work that you do. So we're always grateful for the work done locally and in my riding as well.

You've been very clear about the assistance that the LHIN gave to the process through which Devon was placed in your facility, and in essence, you're supportive of the whole principle of the LHIN structure. This is your opportunity to tell us: Do you have any recommendations for change, anything that you've seen as being a stakeholder and participating with the LHIN that you see that could enhance health services in this particular area?

Mr. Brian Dunne: We need to continue to engage the community, to engage the partnerships. I always go back to the person, because that's why we do all of this. And so, is the system seamless for the person? We hear from families that they have to tell their story many, many times, and I think through this collaborative, integrated process, a family has to tell their story once, and the providers come together in a seamless system, hopefully to provide the best care and support to that person.

Ms. Helena Jaczek: Has there been any development of any sort of common referral tool or assessment that many agencies use?

Mr. Brian Dunne: Yes. We have a collaborative assessment process for community services now through the collaborative, which is part of the change that's happening within the South West LHIN, and also the coordinated access through the CCAC. So I think that has been helpful and is less confusing for families, and hopefully better outcomes for the person.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Mr. Dunne, for being here and for the great work that you do in the community. I also have a great Participation House project in Durham region that did some wonderful supportive work for our most vulnerable citizens, so thank you for that.

You're in a somewhat unique situation because you're funded by two different ministries. You mentioned that. I'm assuming you get the money through the LHIN from the Ministry of Health and then get separately funded through MCSS. Could you maybe comment a little bit further on how the LHIN has been helpful in making the process easier for you in being able to bring a more coordinated approach to services for your clients?

Mr. Brian Dunne: Certainly. Some of the areas that we see that are complex are the transitional-age youth

moving from the children's system to the adult system, regardless of which ministry that is in the adult sector. Services for children are mandated to some degree. When they move to the adult system, they lose school, so that full-day sort of program that families have that they rely on is no longer there. And that's across the two ministries; I think we see the issue in both.

Certainly, I think there's been an acknowledgement that the ministries need to work together to have a more coordinated approach for that transitional aging from children to adults so that the families have a bit of hope that there will be something there for them when their child turns 18 or 21, depending on the transition from the children's system. Certainly, South West LHIN has been paying some attention to that population, and the families are incredibly grateful for that.

Hopefully, there will be also some collaboration between the different ministries because when we're talking about people who have very complex needs, whether they have a developmental disability or multiple disabilities, with ministries, we need to work together. So there are some transitional opportunities for families to be able to move through that without the complexities of different funding and mandates. I think the two ministries need to have more conversation about that so that the families don't fall through the cracks of rules and regulations in the different funding ministries.

The Chair (Mr. Ernie Hardeman): Thank you very much. The third party: Ms. Sattler.

Ms. Peggy Sattler: Thank you very much for your presentation, Mr. Dunne. I had a question that really follows along the question that Ms. Elliott asked you. You mentioned the need to draw in housing and transportation, as well as health care and support services. Do you see the LHIN playing a role in terms of integrating housing and transportation along with health care and support services?

Mr. Brian Dunne: I think if we're looking at trying to build healthy communities where we all want to be, all of the supports and services need to work together. That would include housing and transportation, because if a person doesn't have a good place to live that's safe, if they don't have good community supports, if they don't have transportation, those are major barriers to their ability to manage in a community. If you look at the rural areas, transportation is a very big problem. So I think the ministries—I think the LHIN can play a lead role in that. They're in a very good position to do it. Again, I think, because the LHIN can plan and drive decisions locally, they can draw in those local different ministries and different bodies to talk about how we collaborate and work together to create the best possible supports and services in a broad sense for citizens. Whether it's transportation, whether it's the municipality in terms of housing or other services, I think it's in a good position to do that and could take a lead role.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. I'm sure it will help our deliberations as we proceed.

SOUTH WEST COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our next delegation is the South West Community Care Access Centre: Sandra Coleman, chief executive officer. Ms. Coleman, welcome.

Ms. Sandra Coleman: Thank you.

The Chair (Mr. Ernie Hardeman): As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that in your presentation. If you do not use it all and there's four minutes or less left, the government will get the time. If you have more than four minutes, we will divide the time equally between the three caucuses.

Ms. Sandra Coleman: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much, again, for being here.

Ms. Sandra Coleman: You should have a copy of my handout; just check to see if you have that.

Mr. Mike Colle: We're just getting it now.

Ms. Sandra Coleman: All right.

Thank you very much, Mr. Chair, and hello to all members of the committee. My name is Sandra Coleman. I'm the CEO of the South West CCAC. Our board chair, Mary Lapaine, had intended to be here. Not much would keep her from here, other than the legendary snowstorms that occur in Canada's west coast, namely Huron county, which is where she is from. So she gives her regrets and wishes she could be here today.

We believe LHSIA, on balance, is working reasonably well in the southwest, and our suggestions today are intended to strengthen the current framework. The CCAC sector as a whole will be making a written submission with a much more detailed series of recommendations for submission when your committee returns to hearings in Toronto.

Today I'm just going to highlight one of those recommendations and then use a patient's story to explain that recommendation a little bit to bring it to life and also, in that, talk a little bit about the CCAC role, but also then how we and our partners work with the LHIN to improve health care services and outcomes in our region.

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The recommendation, as you'll see, is here. It's about health system capacity planning that includes health human resource planning for professionals and personal support workers to ensure that future investments are aligned with population needs and provide optimum value for taxpayers.

Sections 15 and 16 of LHSIA, right now, require the LHINs and their local communities to engage with them and develop an IHSP, as it has become known—that integrated health services plan. That does set out the vision, the priorities and the strategic directions for the local health system and the strategies to integrate the local health system.

What we're suggesting is that beyond that IHSP, we need a long-term-capacity plan. In other words, what

beds and services are needed and where for each LHIN in order to assess what will be necessary to meet the current and future needs, and that further, that capacity plan needs to look at current and future human resource needs, including professional services, but also critically important support services such as personal support.

Now on to the patient story. This is about Faye and about Home First. In the spring of 2012, Faye fell in her home, which is in lovely Oxford county, and was admitted to the Tillsonburg hospital. During her stay there of several weeks, she lost a lot of weight. She started to become disoriented, as often happens with the elderly. Her health was declining and she missed her home in the country.

When the CCAC care coordinator, Nancy, first approached her about going home, though, Faye, as well as her daughter Robin, were sceptical. They didn't hold out much hope. They were assuming that she was on her way to long-term care. But they decided to try, after a few conversations with the care coordinator, particularly about Home First.

So Faye was discharged to home in July 2012, just as Home First was getting started. Faye was one of the first for Home First out of Tillsonburg. It had been in other parts of our region, but not yet in Tillsonburg. She had her arm in a sling and she had multiple medical conditions. She had 24-hour care from personal support workers through the CCAC, as well as visits from occupational therapy, physiotherapy and nursing. The CCAC care coordinator met her in her home on the day of discharge and touched base in person and by phone several times a week thereafter. I've got to say, though, the first few weeks were not easy. Because of that, at the end of the second week, Faye and Robin—you'll see they're both there in the picture, Faye seated and Robin, her daughter, to the right—made the decision that she would, unfortunately, likely have to move forward with a long-term-care application.

But then, at the start of the third week—we see this a lot with Home First; the first few weeks are tough—but at the start of the third week, Faye's health improved remarkably. The sling was removed; she was able to use her arm without pain; she got around more; her mobility increased. Most importantly, not just her personal health but her personal outlook bounced back quickly to where it had been. Two weeks later, she changed her mind about needing to move to long-term care. She still needed regular help, certainly, but only for a couple of hours a day.

Fast-forward to today—since July 2012—almost two years later. She continues to do well. She has remained in her home. She has not had a single day in hospital or ER since. Her care coordinator continues to check in with her regularly and adjust her care plan as needed. Also in the picture there on the left is the care coordinator, and in the back is Betty, her personal support worker.

From Faye's story, there are two messages that I thought were relevant for the committee regarding the LHSIA review. The first is about the CCAC role. I know

that's been a topic of conversation, so I'll touch on that briefly first, but second, that Faye would not be at home had the LHIN and its many partners not come together with the knowledge that the capacity simply wasn't right in the southwest, and to recognize that we together needed to make changes to the system capacity and shift funding to make that care at home happen. In that, the support from personal support workers was absolutely foundational to Faye's outcome.

Let me talk first about the CCAC role and then a little bit more around those capacity shifts that I'm talking about that relate to the recommendation.

CCACs get people the home and community care that they need to help them live and age safely in their own homes and to heal after a stay in hospital. When someone can no longer live safely at home, we help them find and transition to the right care setting to meet their needs. We serve about 60,000 people in a year, about one in 17 who live in the southwest. Every month there are over 3,000 discharges from hospital to home that we support, and about 250 seniors who transition to long-term care every month. The complexity of our patients is increasing. It's up over 23% since 2009. Now, over 80% of our care is for high- and moderate-needs patients at home and the patients coming out of hospital. The other largest segment would be school health supports.

Care coordination is our core service. It is not administration; it is patient care, and it is essential. Our care coordinators are all health care professionals, mostly nurses. They work directly with our patients, their families and other health care providers to identify each person's individual needs, develop care plans and ensure that people get the right care in the right place to meet those needs. Our care coordinators work in every hospital and every emergency department, with every family physician. In fact, we're on-site now regularly with over 330 physicians as part of their teams, but have connections with all 700 or so physicians in the South West—the same with every school, every community agency and every long-term-care home. So that connected, South West-wide network of care coordinators helps to ensure consistent care and practices across the South West and indeed across the province, through our network of 13 of my sister CCACs. This is essential work that someone must do. Families simply cannot be burdened with all of this coordination activity. The system is too complex; the care needs of these patients are too complex.

Some of the Home First outcomes: Faye is at home because of Home First. This was funded by the LHIN as part of the system capacity planning work that the South West LHIN has led. They call it Access to Care, working with all the system partners. Several years ago, there were literally hundreds of patients in the wrong place—too many people in hospital and long-term care who didn't need to be there—and underutilized community supports, or community services that were in need of expansion, such as home care, adult day programs, assisted living and supportive environments like Participation House, which you just heard about. In other

words, that catcher's mitt in the community needed to be bigger and stronger. So the LHIN funded key roles to lead change, to monitor progress and to support spread from hospital to hospital, as well as with all the community agencies. The LHIN increased funding to the CCAC. Last year, it was a 4.8% funding increase, and that resulted in an 8% increase in the money that we spent on patients and a 10% increase in the number of home visits. Part of that return on investment is because we spend only 3.6% of our budget on administration, and we've been reducing that every year. The LHIN also funded additional adult day programs and assisted living or supportive housing environments. Again, you heard the Participation House example. This level of increased funding to the community's catcher's mitt has to continue if we want to provide more care at home to free up hospitals to provide only the care that they can provide.

Home First also increased our personal support volumes. This has been key to the success. Since 2010-11, before Home First, to today, our personal support visits have gone from 1.3 million in a year to 1.8 million. That's a 40% increase. We also changed the model of care, to have eight-hour shifts with Home First. That made it much easier for our provider partners to recruit and retain staff and to enhance the training to support what are pretty sick people in what is really a hospital-in-the-home setting for this first four-week period of Home First, when they are receiving these intensive services, hoping that then their health will stabilize and, like Faye, they bounce back and then can remain in their home. This model has also meant greater continuity of workers for our patients.

On a broader scale, some of the results: 800 people per month, like Faye, are able to be at home instead of in a hospital or long-term care, so we've diverted about the size of a community hospital out of the 20 hospital corporations and 35 sites in the South West; 168,000 hospital days avoided, and we're on track this year for about 200,000; two thirds of all Home First patients are able to remain at home after that first four-week period on usual CCAC and community supports after that three-to-four-week period; ALCs have been cut in half—those waiting for long-term care. You see the graph here. Those show the ALCs as recently as two years ago at the hospitals, and then declining as each hospital—each of those little tags is the name of a hospital—embarked upon Home First. You'll see they've gone from about 180 down to 92. We also did an economic impact analysis. The link is there; it's on our website. It's showing savings of about \$10 million in one year.

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Again, to relate this back to the recommendation: Beyond the IHSP, what will be essential to really enable health system transformation, of which I think Faye is a prime example, will be this type of system capacity planning province-wide, using a consistent approach; to have a plan for how many beds and services we need and where, and it needs to include the realities of funding shifts and different HR models and resources, especially enhancing those important personal support workers.

Working with our LHIN, we are making important changes to improve care that people receive. We know there's much more to be done. In your consultations, you will hear about people who haven't had good experiences. That's a reality; that's where we can learn. Our patient satisfaction rate is 94%; that's the good news. The bad news is that 6% aren't, and we have to keep working at that. But our annual complaints amount to less than one tenth of 1%.

Overall, though, the system works well. It's getting better, but our population is aging, so it's only going to get tougher.

We support the changes that are under way to more fully engage primary care and planning and integration, especially health links. We see a lot of benefit from that type of functional integration, having CCAC care coordinators work on-site with every physician and health link, coordinating care for those high five—that 5% of the population that consumes the majority of the health care resources.

Structural change to the health care system is the most costly and disruptive form of change. It absorbs time and energy at every level, from leadership to the front line. It really should only be considered when it is truly the best solution to an issue or problem. The result must be worth the price.

Home First would not exist in the southwest if we were back to being seven individual county-bound CCACs, the way that we were in 2006, or if, as some suggest, care coordinators were dispersed to be part of hundreds of disconnected primary care practices or disconnected hubs in the southwest. There would be no way for those siloed care coordinators to then ensure consistent care across the southwest, let alone the province. And what about people without a family doctor? Our 35 hospital sites would also then need to connect with hundreds of primary care-based access points or multiple hubs instead of one integrated organization. All Ontarians would lose a single point of access to home and community care, to care in schools, to care in long-term care, and to all other parts of the health care system that we are an access point to, working in partnership with others.

Dispersing accountability for care coordination won't work, so what will? We have to support and create that long-term plan to ensure quality care and, to that end, there's a series of position papers. The links are here.

Thank you for the opportunity to speak with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. You're 29 seconds short of the full time. Thank you very much for your presentation. It's much appreciated and very helpful in our deliberations.

Ms. Sandra Coleman: Thank you.

DALE BRAIN INJURY SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is Dale Brain Injury Services: Sue Hillis, executive director. Thank you very much, Ms. Hillis, for being here

this afternoon. We thank you for the time you've taken to come. As with the others, you will have 15 minutes to make your presentation. You can use all or any of it. If you have time left over, less than four minutes, we will give it to one caucus; more than four minutes, we'll divide it equally among the three caucuses for questions and answers, to the extent that 15 minutes allows. With that, at this moment, those 15 minutes are your 15 minutes. Thank you.

Ms. Sue Hillis: Thank you. Good afternoon, Mr. Chair and honourable members of the committee. Thank you for the opportunity to present to you today. As the Chairman said, my name is Sue Hillis, and I'm the executive director of Dale Brain Injury Services, which provides assisted living, supportive housing, outreach and day program services to adults living with the effects of an acquired brain injury across the seven counties of the South West Local Health Integration Network geographic area. We receive half of our funding from the South West LHIN and half from the Ministry of Health and Long-Term Care directly.

As you may be aware, acquired brain injuries are the number one cause of death and disability for individuals under the age of 45. Every day in Ontario, 44 people acquire a brain injury. These folks need a multitude of supports and services to assist them in making a new life while dealing with their physical, emotional, behavioural and cognitive challenges. They need help acquiring and maintaining skills to enable them to participate in their community and attain their maximum level of independence.

We have found that some of the fundamental barriers to successful community placement for individuals are housing and transportation issues, as mentioned by my colleague Mr. Dunne. This is not unique to this population. When longer-stay alternate-level-of-care patient reviews were done in hospitals, not just here but across the province, it was discovered that it was as much a housing problem as a health problem that was preventing someone from going home. As well, if transportation was a barrier to accessing their primary care provider or other health services when home, they could not go home, as it would likely result in more acute situations.

As the LHIN continues to work towards integration of services and improving the local health system, it must work with the other sector partners to ensure that the social determinants of health are addressed, in order to be successful.

I'm speaking to you today with the perspective of my current roles as well as almost 25 years working in community-based health care, and five and a half years spent as a bureaucrat working in the southwest regional office of the Ministry of Health and Long-Term Care under two governments and three different Ministers of Health.

Since the inception of the South West LHIN, I have had the opportunity to sit at a variety of tables sponsored by the South West LHIN and participated in several planning and engagement activities, some of which provided

recommendations to the LHIN on investments they were considering. I think it's fair to say that I can give a reasonably educated opinion about the decision-making styles and processes of the two models, the LHIN and the regional office, at least in the southwest.

I believe I have given more input and, I feel, have even had a small amount of influence on some decisions made by the LHIN, much more so than I ever had working in the regional office. Local input and local decision-making is vitally important to ensuring that people get the supports and services they need in their local communities.

I'm the co-chair of the southwest community services council, which is a 10-member group that represents the 65 community support service agencies in the South West LHIN and which was formed in 2010. The 65 agencies wanted to have a body that could facilitate collaboration and knowledge transfer among the agencies, oversee projects and enhance communication with the LHIN and other community partner networks, with a goal to improving client services across the LHIN area.

The council has overseen several projects, including the development of some community performance indicators, which were ultimately included in the multi-sector service accountability agreement; the implementation of common assessment and referral tools and processes; and a LHIN-wide common client-satisfaction survey for the community support service providers. I'm happy to say that the South West LHIN community support service organizations, overall, have averaged 93% satisfaction with our services for the last three years.

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Last year, the council presented to the South West LHIN board on the importance of providing a base increase for CSS agencies, which has not occurred for several years. We had the opportunity to outline the potential impact on the clients in our LHIN area of another year with no base increase. As well, we presented the likely effects on other parts of our southwest health system resulting from this erosion of services, and the ongoing human resource challenges, such as recruitment and retention, arising from this. We were not successful in convincing the South West LHIN board to make an investment in an overall base increase for CSS this time. However, it was a good opportunity to educate the board and, hopefully, influence some later decisions.

Local input through community engagement, and local governance for planning, funding and accountability, is a vital component of the LHIN legislation which needs to be retained and strengthened. Community members sitting as governors of the LHIN, making decisions on investments that will directly affect the lives of their families, friends and neighbours, ensures that they view the decisions through the lens of someone who truly understands the unique characteristics of the area, the providers and the citizens. I'm sure that many of the LHIN board members could picture their friends and neighbours as we told the client stories and described our services and the impact that having less service might have on their communities.

Some might argue that these types of investment decisions should be made by a more objective party, perhaps sitting in an office in Toronto, but I think local governors are very committed to working with their partners to make a difference in their community. Accordingly, the health service providers feel much more like partners and strive to work with and understand the pressures on the governors when they know that the governors truly understand their community and the providers' pressures. We are all aware that decisions are challenging, with scarce resources, and can work together to maximize what we have.

For the last few years, I've been a member of the Health System Leadership Council, an advisory group to the South West LHIN, perhaps similar to the advisory panel described in recommendation 5-13 of what is known as the Drummond report. Our local Health System Leadership Council is made up of representatives from various sectors and stakeholder groups, whose purpose, in addition to providing advice to the LHIN, is to guide and lead change efforts across the system. People sit around that table with a system perspective and make decisions and recommendations accordingly.

The Health System Leadership Council was also very involved in the development of the most recent integrated health services plan. As well, there was input sought from all health service providers and a large number of stakeholders.

With this particular IHSP, the South West LHIN has really focused on educating HSPs about the importance of aligning their strategic directions with those in the IHSP. There seems to be a much stronger understanding and sense of the need for responsibility and accountability across the HSPs, to be aligned and to assist in achieving the goals in the IHSP and improving the system for citizens across the southwest. This is certainly an important step forward towards ensuring that all HSPs are engaged in the system and that individual providers are no longer making decisions in isolation.

I think this is one area that could be strengthened even more, with the LHIN taking further advantage of the power available to them. The indicators or performance metrics in the IHSP are still very acute care-focused—reflective, I'm aware, of the ministry-LHIN performance agreement—but going forward, these metrics need to reflect all aspects of the system, including the community, which is where we are trying to shift care. As well, there need to be more metrics that reflect our interdependencies and the need to collaborate to provide the optimal care for our community members. These, then, could be included in the various sector service accountability agreements, so they could be monitored by the LHIN.

There is also opportunity to develop metrics that show that we are working further upstream, focused on prevention and wellness. This would mean that the LHIN would have to engage further with community health and social service providers, including housing and transportation, and have more responsibility for other partners such as

health units and primary care. There are good relationships in place in our LHIN, but more could be done if the LHIN had more direct influence on these partners.

Thank you for your attention.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have enough time for everybody to have a turn at it. We have about two and a half or two and a quarter minutes per caucus. Mrs. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation—very interesting. I just had one factual question I wanted to ask you about first, about the fact that you receive half of your money through the LHIN and half from the ministry directly. Is that because of the nature of the work that you're performing? Is there specific money allocated for brain injuries?

Ms. Sue Hillis: Yes. The ministry-managed programs have retained some of the funding for brain injury programs across the province. We're considered to be a provincial resource, so we actually have beds that are a provincial resource as well.

Mrs. Christine Elliott: Okay. Thank you. The other question that I wanted to ask you about was: The council that you're sitting on, the community services council—is there one in every LHIN? Is that something that's mandated? I should know that, but I don't.

Ms. Sue Hillis: No, it isn't. We developed this on our own. The agency has determined that we thought this was a good idea, and several other LHINs' agencies have begun to develop councils as well, or some collective body. But no, it's not mandated at this point.

Mrs. Christine Elliott: It seems to me a really good way of bringing together those agencies that may be funded both by health and community and social services, to take those not strictly health-related factors into consideration, and to make sure that that is included in the entire package, so that you can see the client holistically. Is that the purpose it was intended for?

Ms. Sue Hillis: Well, the purpose is to improve client lives and the services that we provide, so yes, that would be—

Mrs. Christine Elliott: That's a really good suggestion. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Sattler?

Ms. Peggy Sattler: Thank you very much for the presentation. I was really interested in your recommendation at the end of the presentation about additional metrics. In particular, you mentioned metrics that reflect our interdependencies and metrics to show that we are working further upstream. I wondered if you had specific ideas in mind when you made those recommendations. What would that look like? What would be metrics that reflect our interdependencies and metrics to show that we're working further upstream?

Ms. Sue Hillis: Well, to start with, the interdependency piece: We're just in the process, as has been mentioned, of developing coordinated access here, through the CCAC, for all community services. I think that, going

forward, it would be a good idea to now reflect on how we're working with that coordinated access, both from the community support service side as well as the CCAC side, to hopefully show improvement in terms of access for people as a result of that interdependency. That would be one example.

Similarly, talking about wellness and working upstream, we really don't measure our prevention and wellness programs at this point, certainly not as part of—unless it's a service that we're providing. We're showing output, the number of people who have gone through the program, but not really outcomes of those people. So I think it would be important to develop some outcome measures that would really reflect whether we're making a difference down the road.

Ms. Peggy Sattler: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you, Ms. Hillis, for presenting today.

You also mentioned a couple of fundamental barriers. I have heard of this reoccurring situation—the housing and the transportation issue. Can you just quickly describe how the outcome of the people that you serve would benefit from the housing and transportation—what it looks like now without it, and then what it would look like if it was integrated into the LHINs?

Ms. Sue Hillis: It's very difficult to find accessible and/or affordable housing. The combination is almost impossible to find. So we find that we're putting very vulnerable people in less-than-safe housing. Obviously, it makes them less successful if they're in an area that is not appropriate for them. I think it often sends them back to other situations that we're trying to prevent, where they may end up in long-term care or in hospital because they can't manage.

Similarly, the transportation issue, particularly for our rural clients—they're unable to get to our day programs and our group services unless we have staff picking them up.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much for your presentation. I'm also very interested in this Health System Leadership Council. How many people are around the table, approximately?

Ms. Sue Hillis: Approximately 20.

Ms. Helena Jaczek: I presume you report into the board of the LHIN. What exactly is the connection?

Ms. Sue Hillis: It's not a direct reporting relationship. It's an advisory relationship.

Ms. Helena Jaczek: Yes, but how do you physically do that? Do you do that at LHIN board meetings, or do you write a report?

Ms. Sue Hillis: No, the LHIN staff reports through to the board.

Ms. Helena Jaczek: Okay, so you don't physically come together. Do you have public health at the table? You've talked about the LHINs—

Ms. Sue Hillis: Yes, but they're on the health system leadership—

Ms. Helena Jaczek: They're on that particular group.

The LHIN legislation requires something called a Health Professionals Advisory Committee. Are you aware if that's where your group came from or of it's an adaption of that?

Ms. Sue Hillis: No, it's not directly an adaptation of that.

Ms. Helena Jaczek: Are you aware that there is another committee—

Ms. Sue Hillis: Well, there was earlier on. I'm not aware at this point.

Ms. Helena Jaczek: Okay; I'm sure we'll end up clarifying that with the LHIN itself. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

SOUTH WEST PRIMARY CARE NETWORK

The Chair (Mr. Ernie Hardeman): Our next deputation is South West Primary Care Network: Rob Annis, co-chair. Welcome. Thank you very much for your presence today. We look forward to your presentation. You will have 15 minutes to use as you see fit. If there's less than four minutes left, one caucus that will be taking the time; if there's more than four minutes, all three caucuses will have questions. With that, your 15 minutes starts now.

Dr. Rob Annis: Thank you very much, Mr. Chair, and committee members. It's really great to be here to give input on this subject. My name is Dr. Rob Annis. I'm a family physician in Listowel, Ontario, which is about an hour and a half away from here, where the weather is not quite as bad as here today, luckily. I'm also on LHIN staff as the primary care lead. I'm one of four primary care leads. Each of us works one day a week with the LHIN. I'm co-chair of the South West Primary Care Network. This is a structured way of engaging primary care in regional and local planning that we've put together over the last two years here in the LHIN. I've been on many committees with the LHIN since about 2008, as well, so I guess I'm well versed in how the LHIN has been doing. I did speak with our primary care network, which is a group of primary care leaders from around the geographic area, to get their input for the comments that I'm giving you.

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Basically, I have two points from the primary care world, and one is that the South West LHIN has enabled front-line primary caregivers to have a say in regional planning, from a voice that puts the system first as opposed to any particular viewpoint. That has been very much appreciated. The second is that the LHIN could be given more control, in my opinion, over primary care accountability and resource or capacity planning for primary care. Just to go into that a little bit, before the LHINs existed there were 800-plus family physicians and nurse practitioners in this area who were more or less doing their own thing, disconnected from the system. If

people were planning programs, their health care organizations—CCAC, mental health organizations and some of the other presenters here today—they had no structured way to engage primary care in any of those programs. So when they got to our doorstep, frequently they didn't work for us because we hadn't had input before. It was a loss in the system. Many decisions were made in Toronto; we didn't really have a voice in that at the ground level.

With the LHIN, starting back in 2006, especially in the southwest, there has been a very passionate and hard-working attempt to engage primary caregivers. With that, I mean mostly family physicians and nurse practitioners in the work that they're doing, and bringing them to the table with other health care organizations, CCAC, mental health, community service providers, so that more or less we're planning together so that things work better all around. That culture, that work that they've done to really welcome us to the table has paid off and has become more structured, and part of that structure is the South West Primary Care Network, which I mentioned. Again, this is a group of primary care leaders from around the LHIN who meet regularly to offer advice on regional program planning, as well as communicate backwards to the local areas about those particular issues. So we're sort of fanning out in both directions.

To give you some examples of things that we've talked about and maybe successes that we've had with the LHINs, I've just made a short list here:

- SPIRE is an electronic medical record solution that downloads hospital data directly into family doctors' electronic medical records;

- MRI wait times, not so much that we've pushed that, but certainly the primary care world has really appreciated what the LHIN has done with MRI wait times in our LHIN;

- The primary care network has discussed, in particular, the location of CCAC flex clinics, which are wound care clinics mostly, cancer screening and the diagnostic assessment programs through CCO. We've given input into those programs and the rollout of those in our LHIN;

- We had discussions about the loss of thoracic surgery in the Owen Sound area. We had a lot of discussions about hospice palliative care development in the north, which was a big issue for a while;

- We are sort of leading referral reform in the province. Referral reform between GPs and specialists is a big problem and needs to be changed. We're starting to develop a process in engaging other provincial organizations in potentially solving this;

- We've had success with colonoscopy access in London, which was horrible, and removing barriers to dealing with Health Care Connect to roster unattached patients, specifically we've had success with diabetic unattached patients;

- Health link development: You've heard of health links. Health links are supposed to have a very strong primary care component—voice, input, involvement—and that has been difficult to do provincially. What we're

doing is developing the South West Primary Care Network locally, in line with the health links geography. For example, the Huron Perth Health Link, which my particular family health team is the lead for, is working with the Huron Perth Primary Care Network, which is a subgroup of the South West Primary Care Network, so we have a very structured way of engaging family physicians and nurse practitioners in the work of the health link as it goes; and

- Partnering for Quality and Partnerships for Health: These are both South West LHIN initiatives. Partnerships for Health was a quality improvement initiative that touched more than 70 practices in our LHIN to improve diabetic care using QI, quality improvement, techniques and data mining. It has been written up in at least two peer review journals with very positive results. Out of that has grown Partnering for Quality, which is a LHIN resource in terms of IT support for data mining, for practices, as well as quality improvement coaching that is well used.

So all of these are examples of how the LHIN has touched primary care and we have a really great working relationship. There are very hard-working staff, frequently stretched by what's coming from the province, and I really have to give them credit as a staff for engaging us in the process.

The time is ripe, in my opinion, to move forward with more LHIN involvement in primary care, specifically around accountability and resource planning. Right now, the LHIN really has no levers into changing primary care. They've done many good things despite that. They do control the finances for community health centres, but in no way for family physicians or nurse practitioners. I think there are certainly barriers to having them fund family physicians that you would likely see from the OMA, but there are probably interesting ways to get accountability in the system, either by holding primary care boards, which are developing right now in the CHC family health team, a nurse practitioner-led clinic world—holding boards accountable for some of what they do or potentially having financial mechanisms like they do in the medical home model in the States where if you do do certain QI and access initiatives in your practice, you are given a larger percentage of base funding. So I think there are, potentially, mechanisms to give the LHINs more control over what happens in the regional and local primary care world to drive quality in that sector.

In resource planning, right now there's absolutely no control. If we have sections or a LHIN that need primary care, really, we leave it up to that community to hope to find somebody. I think that a more regional approach to planning, so that we can aim community health centres or family health teams or even solo practices at certain areas, is something that would really help the people in our LHIN.

Those are my two basic points. It's a very positive report from the primary care world for the existence of LHINs. I've really appreciated the way they've worked

with us, and I'm happy to take any questions if I have a few seconds.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have a question from each one. We have about two minutes for each party. We'll start with the NDP, the third party: Ms. Sattler.

Ms. Peggy Sattler: Thank you very much. I just had one quick factual question. This South West Primary Care Network: Is there a similar network in place in all of the LHINs across the province or is it unique to the South West LHIN?

Dr. Rob Annis: I would say that the South West Primary Care Network was the first one off the ground, but what's happened is that every LHIN hired a primary care lead about a year and a half ago. So that's my job, as well. The South West Primary Care Network existed before my job did. In this one, it kind of grew up without those hires, but the mandate of every one of the primary care leads is to formalize a network in their respective LHINs. That's happening in each LHIN right now.

In particular, in Champlain, they're very well advanced. In each health links geography, they have a local primary care network with a chair picked and regular meetings, and in the Central group as well. In the South East LHIN, it also is fairly well advanced. I think those are the three that are furthest along in the process.

Ms. Peggy Sattler: Have there been challenges for you to find primary care physicians, to bring them in to this LHIN network that you're creating?

Dr. Rob Annis: Yes. The usual term is "herding cats," so yes.

Ms. Peggy Sattler: So how have you dealt with that?

Dr. Rob Annis: Again, the lack of levers for the LHIN makes it difficult, but what we've been able to sell is input. Family physicians, at the end of the day, want to do a good job and they want the system to work. They know it doesn't, frequently. It makes their day harder, plus it makes things worse for their patients. Having the ability to have a voice in what happens is the selling card, and people buy that.

The Chair (Mr. Ernie Hardeman): Ms. Cansfield?

Mrs. Donna H. Cansfield: Thank you very much. A very interesting presentation. From the statistics, the area you represent has probably one of the fastest-aging populations, and yet I haven't read anything about what you're doing in terms of dementia, Alzheimer's, and dealing with aging and rural issues.

Dr. Rob Annis: Yes, that's fair. I'd have to think about the agenda to see where—I mean, certainly, the work we've done with cancer and connecting with many of the groups—most of our work is with elderly people with chronic disease, actually.

The health links initiative, as you know, is aimed at the top 5% of users, which are people with chronic disease and tend to be the older age group, although not always. And so a lot of what we're doing is involved with them, but I don't think we've done anything *per se* with dementia. I think that's probably fair.

Mrs. Donna H. Cansfield: So it is always an opportunity.

Dr. Rob Annis: Yes.

Mrs. Donna H. Cansfield: Thank you very much.

The Chair (Mr. Ernie Hardeman): Ms. Elliott?

Mrs. Christine Elliott: Thank you, Dr. Annis, for joining us today and for your presentation. A lot of presenters have mentioned to us that primary care should be included as part of the work that's being done through the LHINs, and so congratulations on the success of your network.

From what you're saying, it sounds like one of the major barriers to it being fully embraced is objections that other groups—primarily OMA—might make, so that we'll have to do indirectly what we can't do directly through some of the other funding mechanisms. Am I taking the right point from this? Or is this—

Dr. Rob Annis: Yes. I certainly don't feel comfortable speaking for the OMA on this particular issue, but I would guess that funding family physicians through LHINs would be problematic to develop. Certainly, the OMA is on board with the health links development, which does have a measure of accountability in it. Plus, the OMA is agreeable to the governance development that's going on right now in the primary care world. I think there would be ways of—and I think family physicians would be for this; it would have to be clever, I get that—adding accountability regionally so that things can work better at the local level for patients. A lot of money goes to family doctors in the primary care world right now, and it really is without any feedback on whether it's a bang for the buck.

1530

As a family physician, I'm comfortable and confident that what I do every day is helping people, but I want to see the data too. I think there is a lot of buy-in for having data mining and accountability for what we're doing every day with the taxpayer dollar. It's only been recently that we've had the EMRs so we can start to get at this data, but now that we can, I think we need to develop those mechanisms, and that will really drive improvements to the system.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. As was mentioned, we have heard a lot about primary care being involved. I think you're the first doctor who came up with the thought that it was a really good idea, so we appreciate that.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the South West Local Health Integration Network: Michael Barrett, chief executive officer, and Jeff Low, chair. Welcome. Thank you very much for being here. Actually, you live here; right? We're visiting. But thank you very much for being here this afternoon to help us with our public consultation. As with all the other delegations, you'll have 15 minutes to make your presentation.

and you can use it any way you like. If there's less than four minutes left over, one party will ask the questions or make comments; and if there's more than four minutes, I'll divide that as evenly as I can to make sure everybody has a say. With that, the floor is yours.

Mr. Jeff Low: Thank you very much, Mr. Chair. I am Jeff Low, the board chair of the South West Local Health Integration Network. I'm here today with Mike Barrett, our CEO. I want to thank the members of the committee for taking time out of a busy schedule, and at a very cold time of year, to travel around the province and come to London, Ontario this afternoon, as you undertake the review of the Local Health System Integration Act.

We're certainly pleased that we could have a few minutes of your time to talk about the role that the South West LHIN plays in creating what we think is a sustainable, high-quality health system and, more importantly, the role that we play in improving the health system for patients, clients and residents in all of our communities.

As board chair, I am delighted that so many of our colleagues from the South West LHIN and the other health service providers have joined us today as well, talking about the role the LHIN plays and the role that they play in health care throughout the southwest and hopefully providing you some serious input on how LHINs can be better and serve the population better moving forward. I hope that we'll be able to address the committee's questions today and assist this committee in fulfilling its mandate with the review.

I'm going to pass it over to Mike for his comments, but before that, I would like to talk about the LHIN in general.

I've been involved as a volunteer in health care in the southwest for over 20 years. I was here before LHINs, and I can honestly say that the difference is remarkable, in my opinion. I remember what it was like back then, before LHINs. I remember district health councils and some well-meaning people who tried very hard to do the very best they could, but the difference is remarkable. Having seen both models in progress, I can't imagine a program or a health system moving forward without something like a LHIN—call it macaroni, if you like—on a moving-ahead basis. We all live in this area, in the southwest. All the people you've heard from today are from the southwest. They're neighbours, they're colleagues, and we're all working to make the system better. I hope the LHINs are here to stay—as I say, whatever you want to call them—because I think they do make a difference, and I would ask you to bear that in consideration as you consider your deliberations as you go ahead.

I was also the board chair of the London Health Sciences Centre for two years. I was on the board of the London Health Sciences Centre for many years, so I get it when it comes to health care.

Having said that, Mike, I'm now going to turn it over to you, please, and maybe to take the document we handed out and share some examples of progress.

Mr. Michael Barrett: Great. Thanks, Jeff. Thanks, Mr. Chair, for having us today. My name is Michael

Barrett. I'm the CEO for the South West LHIN. I appreciate the committee taking the time to talk with us today.

There are two documents that we circulated around. One is our speaking notes, and the second one is a handout, which I'll refer to throughout my presentation.

I've spent the last 14 years in health care working with the Ministry of Health regional office here in London, and I've also held a number of positions with London Health Sciences Centre, St. Joseph's Health Care and the Children's Hospital here in London as well. I came to the LHIN in 2007 and was appointed to the CEO in 2008 by the board of directors.

Over the next eight or nine minutes—and we're trying to make sure we save enough time for questions for the committee members—I'd just like to talk about the advantages of LHINs, what we think the advantages of LHINs are and how our work has positively impacted the population here in the South West LHIN.

One of the first advantages, we believe—and this going down that first page of the handout—is less bureaucracy. You've heard this from a couple of speakers already. The 14 LHINs replace seven regional offices of the Ministry of Health and Long-Term Care and 16 district health councils. What that translates into for us, here in the South West LHIN, is that we have 40 employees. Previous to us being here, the district health council, plus the regional office, had 80 to 90 employees, so a significantly higher number than what we have here now. We believe that LHINs are actually reducing big government, not creating big government.

I've worked in the regional office. I've worked closely with district health councils. Both of those organizations were missing the key part of decision-making, and that's the decision around the allocation of funds. Without that decision-making on funding, these organizations didn't have the ability to implement their work and, more importantly, influence system partners. So it was very difficult to make system change.

LHINs now have the planning work undertaken by DHCs and the transactional funding responsibilities of the regional office and have the ability to make these funding decisions, which I referred to. Not only do LHINs have the authority to make decisions around funding allocations, plus much more, we're doing it with less people than what had existed in the system before us.

The second advantage of LHINs, we believe, is local decision-making. I'm sure you've heard this at other committee meetings. All of our decisions of the LHIN, including funding decisions, are made locally at our board meetings that are open to the public. All of our board agenda packages are posted publicly on our website five working days in advance. The third part is that local health service provider boards have been maintained. We believe that's a strength within the system.

The monthly meetings of the South West LHIN board have been held in all corners of the LHIN, including rural and aboriginal communities. Our board has held its meetings in communities from Port Rowan to Tobermory, and, after eight years, we have visited most towns

across our geography. We've also had a board meeting at the Chippewas of the Thames First Nation and another board meeting at the Kiikeewanniikan healing lodge on the Munsee-Delaware First Nation. The list of those previous board meetings are on the back page of the handout as well for 2013-14.

What that means, and you've heard this from other presentations, is that no longer are decisions made in Toronto by someone in the ministry. That used to be what they'd say: It's someone in the ministry. They're made by board members who live here in our communities. The public sees them in the grocery store or at the arena and at community events.

Another important part is that the media is there for all of our board meetings. Whether we're in Owen Sound or Tillsonburg, the media is there. They can see first-hand the staff recommendations, the debate of the board and, finally, the decision. And the media can interview the board chair immediately following the meeting. So there's no filter or barrier between the decision process and the public.

The third advantage for LHINs for us is increased accountability. LHINs have a formal accountability agreement with the Ministry of Health and Long-Term Care. We then have accountability agreements with our health service providers. We have over 200 service accountability agreements with our 150 health service providers. Those agreements did not exist prior to LHINs, with the exception of some simple hospital service accountability agreements.

Another advantage to LHINs is a system approach to health care, breaking down the silos. The health care system functions differently than it did in the past. Partnerships have been created and are enhanced where they may have not existed before.

Brian Dunne mentioned earlier the relationship between University Hospital and Participation House. I won't repeat the story, but there's an example of where a patient went from the most complex place in the health care system—an ICU bed—to a community organization, living in a residential setting. Not only is it the most complex, but it's the most expensive. So we've been able to help bring those partners together. It's not all us; it's the partners working as well to ensure that a young man can live independently where he wants to live, in a residential setting. There's a picture of Ricky on page 8 of our handout, which are some of the patients' stories. He's a big Toronto Maple Leafs fan.

Lots of other stories are captured in our handout today. You're hearing some from the presenters today, and I'll also let you look at that handout.

Health performance: We're setting targets and measuring performance. If our health service providers do not meet those targets, there are interventions that we take. It starts with a simple meeting and can escalate to a performance improvement plan if the provider is not meeting the targets. That's really key, that those targets set the standard for what we want to see within the system in terms of system change.

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Finally, community engagement: We do extensive community engagement in a number of ways. You'll see on that back page of the handout that at every second board meeting, we do a board-to-board engagement session. We also do a community engagement session. So last Tuesday night, on a cold Tuesday night in Goderich, we did a board-to-board session and a community engagement session, where we engage board members from health service providers across and within that community. If we're in Tillsonburg, we hold the meeting there; if we're in Goderich, we do it there—in Owen Sound, and all around the different parts of our LHIN.

We also ensure that we connect with physicians—we do physician engagement—our local MPPs and also with municipal governments. A great example of meeting with municipal governments: Sandra Coleman had spoken about the redistribution of complex continuing care and rehabilitation beds across the LHIN. We had three hospitals that, through this process, were actually getting a reduction in the number of beds. We're taking the resources and putting them into a place elsewhere within the LHIN that needed those resources.

The municipal councils were quite concerned, but they had the opportunity to meet with us face to face. I had to go present in front of these municipal councils, and they gave me a rough ride. I also met with county council. But there they had the chance to ask someone face to face, in person, why we were making these decisions, why we had those recommendations and why we were going about doing this.

What I'm trying to convey is that we take community engagement very seriously. With a large LHIN with 150 health service providers and includes 27 emergency departments—it takes about six hours to drive from tip to tip of our LHIN—it's not easy, but we engage the public and stakeholders to make sure they're informed and have input into our decisions.

Just to wrap up: We really remain humbled by the amazing work done every day by our front-line providers in the hospital community and long-term-care settings. As the South West LHIN, we're proud to have a leadership role in this system.

But we do believe that we can do better and that changes to the LHSIA legislation will help us accomplish that.

You've heard about the need to make changes around primary care. We're fully supportive of that, and I think, with primary care being the foundation of the health care system, those changes will be beneficial to all of us.

So LHINs are not perfect, but we do believe that we have brought positive change to the system. We're so pleased, as Jeff said, that so many of our health service providers are here today to give the committee advice and input so they can make the necessary changes with the LHSIA legislation.

Thank you, and we're happy to answer any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about four minutes left for questions—

just slightly over four—so if we can keep them all very short. We will start with the government side.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. I'm going to ask the same question I asked before. You identified the large proportion of seniors, and yet I see no Seniors Strategy in any of your notes or in any of the handouts, so that's one.

The other is, I want to ask you about the issue of how you could see reducing—you have 150 organizations. Obviously, the administration costs are high. Do you participate actively in helping to merge or integrate services?

Mr. Michael Barrett: Sure. Through you, Mr. Chair, to the question about seniors: A significant amount of our work relates to seniors. Two examples that I'll give are the Behavioural Supports Ontario program, which provides additional funding and training to long-term-care homes—here in the South West LHIN, we have 79 long-term-care homes—to ensure their staff are trained and knowledgeable about how to deal with seniors with dementia and with behaviours. That funding is allowing those long-term-care residents to remain in their homes longer.

Mrs. Donna H. Cansfield: But that's done through the CCACs.

Mr. Michael Barrett: It's funding that's provided through us, through the South West LHIN.

Mrs. Donna H. Cansfield: Right. So do you do the monitoring and assessment, then, of those programs, once they're in?

The Chair (Mr. Ernie Hardeman): Time's up. Ms. McKenna?

Mrs. Donna H. Cansfield: Sorry.

Mrs. Jane McKenna: Thank you so much for your presentation today. I just have a couple of questions.

When we were in Niagara, there was a lady there named Pat Scholfield, and she was trying to find out when these meetings were on and decided, instead of complaining, she was going to just dive in so she could have some input of what she was doing.

She said that it was so difficult to actually find out when these meetings were, and even when she got there, there was hardly anybody there for her to give the information to that she wanted to give. Then she was concerned about the information she fed back to them: Where was that going? Because she had a hard time getting any email back from people that she was asking.

My question to you is, where do you actually advertise this so people know where to go?

Mr. Michael Barrett: We do extensive advertising. I'll give this example: We had a board-to-board engagement session and community engagement session in Lion's Head, which is halfway up the Bruce Peninsula. We advertised it in the local paper, we advertised it on the radio station, and we also put it on our website, to ensure that people had that information.

The interesting part is, when I got there, the front row was full of a group of senior ladies, and they said I

should have used this radio station as opposed to the other one. So they gave us advice back.

But we do try and get that message out as clearly and quickly as possible.

The Chair (Mr. Ernie Hardeman): Third party?

Ms. Teresa J. Armstrong: Thank you very much, both to Michael and Jeff, for coming today. Just kind of building on that question, it sounds like maybe some LHINs get the word out better than others when there are board meetings or community engagement meetings. Perhaps that's something the LHIN needs to work on: collaboration with other regions.

We had a presenter today in Kitchener–Waterloo, and it was the first time in a long time that someone mentioned—he was a police chief. He was speaking about how the mental health services, when they go out on calls—how their roles have changed and how the services that they provide should be enhanced.

Do you see that role with what the police are doing now with regard to the escalation of mental health out in the community because of the transformation? If you could elaborate on that, I'll let you—

Mr. Michael Barrett: We've worked closely with the police department here in the city of London, and it is around mental health patients. Mental health patients should not be in the back of a police car; they shouldn't be in the emergency department. They should be receiving supports either in hospital, if it's an acute episode, or within the community.

We work closely with the chief of police here in the city of London to update our mental health crisis response team. With the community mental health provider, CMHA, working with the police and working with us, we've been able to establish that team, and it has been very successful.

The chief is to be reporting back the stats in terms of how much of his officers' time was actually tied up prior to this change versus after. That information will be coming probably in the next six months or so.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, both of you. It was very informative. We appreciate you taking the time to be here.

DR. MICHAEL SHARPE

The Chair (Mr. Ernie Hardeman): Michael Sharpe, professor at Western university. As we're getting the presentation ready, we thank you very much, Mr. Sharpe, for being here. We also want to tell you that you have 15 minutes to make your presentation. You can use any or all of it for the presentation. If you do not use all the time, less than four minutes will go one caucus and more than four minutes will be spread amongst them.

With that, the next 15 minutes are yours. Thank you very much.

Dr. Michael Sharpe: Thank you, Mr. Chairman and members of the Standing Committee on Social Policy.

I'm Michael Sharpe. I'm a full-time intensivist at University Hospital, London Health Sciences Centre. I'm

a member of the coordinating committee for Critical Care Services Ontario. I'm a member of the provincial repatriation committee for Critical Care Services Ontario. I'm a member of the LHSC access and flow steering committee as well as the regional steering flow committee. I've been intimately involved in developing critical care policy for the province of Ontario.

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My comments today pertain to my role as the South West LHIN critical care LHIN lead for the province of Ontario and the work that we've done in the South West LHIN and how this has driven health care policy province-wide.

I must also add that at some point in time, I probably voted for each and every political party that's represented this morning.

Should we go?

Interjection: There's some button you have to push—

Dr. Michael Sharpe: It's F4. If this doesn't work, I don't really—that's fine. It's frozen here.

The advisory board for the province of Ontario was developed in 2007, and we had one critical care representative from each of the 14 LHINs. There was a reason for this, and that was the SARS epidemic.

We all remember SARS. What it taught us was that we have tremendous expertise in providing critical care to patients. What lacked was the system. The system was terrible. We all worked in silos, and we had no organization and structure to deliver appropriate care to all our citizens in Ontario.

In 2010, we had a letter from the regional coroner regarding coroners' cases of patients who did not do very well. It wasn't a failure of appropriate treatment; it was a failure of the system. What they recommended at that time was that, within each LHIN, there should be a defined process to ensure access to each of the services defined as life-or-limb. In other words, if you did not receive appropriate therapy within four hours, your life was at stake or a limb was at stake.

There was a need for a no-refusal policy. This idea of "I'm sorry, we can't accept this patient; we have no beds" had to stop, so we had to change that philosophy. It became "patient first, bed second."

As a result of that, we presented our program to the South West LHIN: a new life-or-limb, no-refusal policy, the first of its kind in Canada. They were fully in support of this, and they provided us with a project manager to carry this out.

It was a lot of work. It was collaboration with all of our stakeholders within the South West LHIN: not only administrators, but physicians of all of our hospitals in the South West LHIN, and also all of the other services that involved critical services, not only within our hospital, London Health Sciences Centre, but community hospitals as well.

So, "patient first, bed second" was our philosophy. With much hard work and the results of this pilot project, two weeks ago Monday was a major breakthrough in critical care services in Ontario. This policy became

implemented as provincial policy in all our hospitals across the province.

Following that, we did better, but we could have done much better. The problem is, we talk about equality of care and access to all critical care services. That's impossible. Our geography doesn't allow that. If you're going to have a stroke, if you're going to have a heart attack, you're better to do it in the lobby of London Health Sciences Centre as opposed to a walk-in clinic in Wiarton. That's the nature of the beast.

What we need to do is to have immediate access of individuals who are taking care of these acute, critically ill patients. Therefore, we went back to the South West LHIN and asked them again for another project manager, so that we could develop the Extramural Adult Critical Care Response Team. That is, we have ICU physicians now on call 24/7 to respond to these people who are calling for help. The family physicians in their emergency rooms in these small community hospitals, where the care of these patients is exceeded—the resources are not available to them. We will respond to them within 10 minutes. We will accept these patients and find the hospital resources to take these patients within 30 minutes.

This has been a tremendous improvement in terms of communications between physicians referring critical care patients to tertiary-care hospitals. Again, this was a result of the hard work that was provided by the people within the South West LHIN.

We also presented this to the provincial board, Critical Care Services Ontario. Our response was lukewarm. A similar response to the life-or-limb policy was lukewarm. That's when Michael Barrett came in and said, "Mike, we've got to go to the LHIN boards across the province. We have to tell them that this is what we need to do." That's what happened, and the life-or-limb policy is now provincial policy.

So, these results show that increasing efficiency of care by ensuring timely access to consultation with critical care intensivists and other consultative services.

Using the one-number system from LHSC—timely referral to the appropriate care institution. We accept them within 30 minutes of the physician calling us.

Optimal resource utilization, such as transport—I'll refer back to transport near the end of this talk.

All life-or-limb referrals are coordinated through the provincial CritiCall system, and that allows us to capture all data.

We improved collaboration by developing an operational algorithm, effective for all South West LHIN hospitals and CritiCall, and aligned one-number protocols within the South West LHIN hospitals, so we're providing immediate care for these patients who need it.

We also enhanced patient-physician health care team experiences by facilitating stabilization recommendations with respect to stabilization and transport of critically ill patients between hospitals in our LHIN. We also maintain a high degree of satisfaction among physicians on both sides of the phone, including the health care teams,

in the handling of life-or-limb patients. These patients will not now inappropriately die because the system did not work.

In 2009, we again went to the South West LHIN for another project. Every time Michael sees me come in the front door, he runs and closes his door. This is another project—again, a project manager—which allowed us to build an interprofessional system that optimizes delivery of care to long-term ventilation patients. It's a small number of patients, but they're consuming a large number of ICU beds in our acute care and intensive care units. These patients often live for months in our intensive care unit.

We've heard about Ricky. He spent over a year in our intensive care unit. It's a cold, unfriendly environment. Ricky is now in the community with Participation House, who care for this patient appropriately. He's now in a residential setting. What a better way to live the remaining years of his life.

This clarified resources needed to effectively, efficiently manage the system and how we deal with people with long-term ventilatory requirements. It also developed an educational strategy to augment all caregivers, and it created tools, care maps and checklists to encourage standardized care. As a result, we now have an 80-page document, which is sitting in the South West LHIN office. It's a systems model to meet the health and supportive care needs of adults living with chronic mechanical ventilation in the South West LHIN. This is what we're going to take to the province.

The next step is to determine how we can manage the resources and what we need in the community to allow this to happen so that we have the knowledge and expertise to care for these patients in the community—not only hospital communities and Participation House, but some of our patients are in their own home with mechanical ventilation. So it's a very complex but very appropriate system for management.

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The role of the LHIN: They're making the system work. They approve access to critical care. They improve flow: taking these patients into our hospitals but repatriating them back to our community hospitals. They decrease the bottlenecks. Remember, if you don't have a healthy intensive care unit in your hospital, the entire hospital breaks down. We have patients sitting in an emergency room, trying to get into the ICU. We stop elective surgeries because we cannot take cases from the operating room because we're full of patients. Some of those patients should not be taken care of because they should be back in their community. So we take a geographical and population perspective. We offer the best care we can in the most efficient and immediate way possible.

Driving to the future, changing the philosophy or practice of physicians, you can only do it two ways: money and data. You don't have money to give them; they're paid well enough. What we need to do is collect data that's accurate so that we can change practice and

we can change the accountabilities of everyone in the health care system: administrators, physicians and so on.

We need to match funding with activity. I think the funding of hospitals is archaic, inappropriate and bizarre. There's something wrong here. We need to take a hold of that and match funding with activity and make that also in line with the accountabilities.

We also need to invest into end-of-life care. We need to match expectations with resource utilization. We all know about the Rasouli cases. Those are becoming more and more frequent. This is inappropriate and inaccurate utilization of health care dollars. The ICU is a very expensive business, second only to the operating room, and we need to use our resources and we need to utilize our monies very efficiently and as effectively as we can. We have to get control of our health care costs, and critical care is one of the first steps to do that.

What I'm really referring to is palliative care. A lot of our patients that continue to be admitted to our intensive care unit should not be there. Let me give you an example: someone with end-stage lung disease. They know they do not want to be intubated and put on a ventilator; they are at their end of their life. But if palliative care fails them, they are suffering at the time of their death, and what happens? They run into the emergency room; they're intubated, and they end up in the intensive care unit. No one wants that, including the patient. That's palliative care, not only within our hospital walls, but also palliative care out of the community. They will develop and form a very important role in how we deal with these patients within our community. There are spots of excellent palliative care systems within our province, but for the most part, we do a lousy job. So that's where we need to invest our future investments with respect to that.

I have nothing more to say. I'll be happy to answer your questions.

The Chair (Mr. Ernie Hardeman): I was just going to say you have two minutes left to say it, and then I find out you didn't fill it in.

Dr. Michael Sharpe: If the committee wishes, I can make copies of this presentation and then give it to them.

The Chair (Mr. Ernie Hardeman): Yes, that would be—

Dr. Michael Sharpe: I apologize.

The Chair (Mr. Ernie Hardeman): Thankfully, you did speak very clearly, and Hansard will record every word that you did say. Copies of the presentation would be beneficial, I think, and I'm sure the committee would agree. With that, I just want to say thank you very much for making the presentation, because I've just about used it up from the time you took—so thank you very much. You were very informative, so that's why we didn't need a lot of time for questions, I'm sure.

CANADIAN NATIONAL
INSTITUTE FOR THE BLIND

The Chair (Mr. Ernie Hardeman): Next is the Canadian National Institute for the Blind, Vijay Chauhan, director of government relations and advocacy, Ontario-

Nunavut, and Sherry Malcho, regional director, west, of services and operations. Welcome, and thank you both for being here. You will have 15 minutes to make your presentation. You can use any or all that time, and any time left over, the committee will use it and ask you questions and make comments about your presentation. Thank you very much for being here.

Mr. Vijay Chauhan: Thank you, Mr. Chair, and members of the committee for giving us this opportunity to speak with you today. My name is Vijay Chauhan and I'm the director of government relations and advocacy for Ontario-Nunavut CNIB, and, of course, I'm joined by Sherry Malcho, who is our regional director of services and operations for western Ontario.

CNIB is a registered charity that provides community-based support, knowledge and a national voice to ensure Canadians who are blind and partially sighted have the confidence, skills and opportunities to participate fully in life. To do that, our specialists work with people of all ages who have experienced vision loss to provide emotional support and personalized restorative rehabilitation services that foster everyday living skills and allow people to remain independent in their own homes. We also offer access to a range of innovative consumer products, assistive devices that make life with vision loss easier, as well as the CNIB library, Canada's largest collection of reading materials in alternative formats like Braille and audio. In addition to our community-based services, we work hand-in-hand with Canadians who are blind and partially sighted to advocate for a barrier-free society, and we strive to eliminate avoidable sight loss through research and public education.

Vision loss is a complex issue, with many underlying challenges. It is common for individuals to feel depressed, angry and alone after experiencing vision loss, and feelings of isolation and dependence are commonly reported. CNIB helps those struggling with the emotional challenges by assisting with the adjustment to vision loss through our essential support services. Our clients have achieved basic living skills, such as how to safely travel. We work with career and employment services providers to help our clients access the information resources they need to build their job skills and achieve a satisfying career. Given that less than a third of Canadians with vision loss are employed—more than half live below the poverty line on annual incomes of less than \$20,000 a year—employability is a key area of concern for this disability group.

When it comes to children and youth, CNIB is an essential, trusted expert in the habilitation of children and support for families. We help children who are blind and partially sighted achieve developmental milestones and grow into successful, confident adults by giving children the support they need to excel. We also provide parents with educational materials, peer groups, access to local resources and workshops on raising a child who is blind or partially sighted.

Our vision rehabilitation services are essential to ensure that a loss of vision does not equal a loss of life,

which is why CNIB's mandate is to help people see beyond vision loss.

CNIB supports the concepts underlying the local health integration networks, whether it's coordinated services that are customer- or patient-focused, services that match community needs, an efficient health care network and the promotion of wellness and independence.

We come before you today in two capacities: as a community health care partner in the voluntary sector and as an agency serving people with disabilities.

In 2006, CNIB and other agencies serving Ontarians across LHIN boundaries made four recommendations regarding the local health integration act. While the act has been genuinely useful in building better local relationships between health service providers, today we would like to focus our comments on an area where it's been less than successful.

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In 2006, we recommended that the drive for local planning and accountability be balanced by the need to account for province-wide priorities and consistency of service and not increase the administrative burden on provincial health care providers. As it stands, the act is silent on the issue of provincial programs, agencies and their interface with the Ministry of Health and Long-Term Care and the LHINs. These agencies provide the best of both worlds: responsiveness to local needs and provincial planning standards, controls and cost-effective centralized structures.

We cross LHIN boundaries and have many funders and several interconnected programs. CNIB would like to see this type of approach considered very carefully in this review. We believe that the scope and quality of services should be consistent from community to community. However, the community support sector in which most of these agencies are represented account only for a very small portion of LHIN budgets, and their attention to planning in this sector reflects that relative budgetary unimportance. In fact, funding allocations to CNIB are not based on the needs or numbers of people who are blind or partially sighted in communities across the province but on previous allocations the LHINs inherited when provincial programs were devolved to them. We believe the current contracts are not respectful of the role we play in patient care within the LHINs, as they are based on an outdated charitable view of rehabilitation of people living with vision loss. As a result of the current multi-LHIN funding model, there is a disappointing inconsistency in the share of service costs in each LHIN.

Patients referred to CNIB by their ophthalmologists rely on CNIB's ability to raise money through donations within each of the LHINs based on the varying levels of LHIN support across the province. A CNIB study conducted in 2011 showed that LHIN contributions to the cost of CNIB services ranges from 77% at the high end to just 31% at the low end. We are also concerned that inefficiencies and added costs have resulted from CNIB having to manage 13 different service agreements that provide identical services across the province.

In 2006, we suggested that applications, agreements, funding formulae, forms and processes be as consistent as possible across LHINs so that service providers who deal with more than one LHIN would not have to detract from service delivery to manage different types of paperwork. In short, that's not happened. Today, there are 13 different interpretations of our 13 different LHIN contracts. It should be inconceivable that there could be more than one interpretation of what constitutes an administrative expense, but there is, and we are required to account for our costs in different ways because of these many different interpretations. Costs and effort that could be dedicated to identifying and implementing program enhancements are utilized instead to remit reports in 13 different formats to 13 different LHINs. I guess I should clarify: We have 13 contracts, not 14.

We are also required to complete 13 different surveys designed to satisfy a single provincial requirement that LHINs report on to the province; for example, French language services. There is a significant cost to this unnecessary duplication of effort, and those costs are ones that we are explicitly not permitted to recover from LHINs or the government. Instead, that funding is coming from charitable donations to our organization. An unintended side effect of the devolution of our services to LHINs was the loss of any province-wide lead for policy and planning in our sector. While we do have local point people at LHINs on financial matters, we do not, generally speaking, even have a local policy or planning lead to turn to. It will be difficult to address the future needs of blind and partially sighted Ontarians without an open dialogue and long-term planning. Disturbingly, at the moment, it appears that it is no one's responsibility.

CNIB recommends that this review considers carefully the need for some central and provincial contracts to ensure equitable service and controls across the province and, to the extent possible, to ensure that there's a consistency in LHIN paperwork so that administrative burden on service providers operating in more than one location doesn't divert resources from service delivery.

CNIB would like to see a more macro approach to planning and include organization or sector-specific point people within each LHIN. Thank you very much for your attention. Sherry and I will be happy to take your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just less than seven minutes. We will start this one with the official opposition.

Mrs. Christine Elliott: Thank you very much for your presentation. You've raised some issues that we were not previously aware of, so it's very important for us to know that. But generally speaking I guess what I'm hearing you say is—and I hope I'm right—that you like the concept of the LHINs, but you want them to be more fully brought in and in a consistent way across all of the LHINs with the paperwork reduced, and recognize that the service you offer isn't going to just be based on charitable fundraising.

Mr. Vijay Chauhan: I think that the one issue is that we need—we're such a small portion of what the LHIN

funds. I mean, hospitals, long-term-care facilities and CCACs—when you get down to our sector, we're this much. You tend to get that much attention. We need a stronger voice at the table. Where we do get a voice, for example, at one of the tables that was mentioned earlier today, Sherry is a member of that council. There are similar tables around the province but, unlike here in South West LHIN where there might be 20 or 30 people at the table, in Toronto there are 100, 150 or 200, and our voice is diluted. We would like the opportunity to have someone that we can go to and talk about the specific needs of our agency, as they are unique—everyone has got unique needs—but we need to have the opportunity to go in and talk about those needs. There needs to be a venue to talk about planning for a community that is going to grow, in terms of blind and partially sighted people, as people age. We need to be planning for that. There's no point person provincially anymore. That person is being devolved or, through this process, that person doesn't exist anymore. So there's no place for us to go and say, "Look, we need to be thinking about what's going to happen in 10, 15, 20 or 25 years."

The Chair (Mr. Ernie Hardeman): The third party: Ms. Sattler?

Ms. Peggy Sattler: Thank you very much for the presentation. You mentioned that in 2006, I think you said, there were a number of service providers who came together to create some recommendations—four recommendations were put forward. I have two questions, and I'll ask them both.

Mr. Vijay Chauhan: Sure.

Ms. Peggy Sattler: You focused today, I think, on just the single recommendation around the issues that you raised. So I'm interested in knowing, first, what were some of those other agencies that were involved in putting forward those recommendations at the time? Second, is this single recommendation that you spoke to today the big issue that you think is still outstanding that needs to be resolved?

Mr. Vijay Chauhan: The other agencies were the Canadian Hearing Society and the Canadian Paraplegic Association, which I believe is now Spinal Cord Injury Ontario. From our perspective, the question of the administrative burden, in particular, and having a voice at the table is the single biggest challenge that we're facing. As we're looking at entering into another three-year contract with our LHINs, we've been told how much we're going to get in terms of the LHIN contribution to our services. We've been told how many people we're going to have to serve for that money, but we haven't been told that in so many words. There's going to be a negotiation, but the starting point is that you're going to serve the same number of people with the same amount of money, and that's something that is going to be a challenge for us. That is going to mean that we're going to be diverting more charitable dollars to cover provincial health services.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you for bringing this to our attention. Earlier today, when we were in Kitchener, we were given a very informative visual of various services provided in the Waterloo Wellington LHIN. Of course, it was the Canadian Hearing Society, the Canadian National Institute for the Blind and the Canadian paraplegic society that in fact, at least from the patients' point of view, were providing service across that entire LHIN.

We've been very concerned about lack of consistency, and one thing, I think, that your three organizations do actually bring is at least a very consistent approach to patients in terms of what you deliver. That's a good thing, but I think we do understand your frustration in terms of now dealing with each individual LHIN in terms of the contract, the way it looks and the interpretation. Is that really the crux of the matter?

Mr. Vijay Chauhan: I think that's precisely the challenge. If I could tell our financial services people, "This is what our administrative cost is," and it's going to be different than what we consider in our accounting process in administrative costs, that's fine; we could still work that into how we work our budgets. As it stands now, I have to do that five or six different ways.

Ms. Helena Jaczek: So is there one LHIN you feel is sort of the ideal model, at the very least? Can you point to one and try to convince the LHIN world across the province that, if only everybody agreed to this, it would work for everybody?

Mr. Vijay Chauhan: Well, I think that the answer to that is actually "No," because my problem is not with any one specific interpretation, although I might quibble about some of those. My problem is that they're not consistent. It's just inconceivable that there could be, in what is supposed to be a health care system, more than one interpretation of the word "administration." Every single LHIN has said, "Well, this interpretation came from the ministry." Obviously it didn't, right? So let's have some means of getting some consistency there.

I think there's a lot of reporting to the province, which is appropriate and important, but the province wants whatever it wants, and it doesn't need to be asked 14 different ways. I'll give one example of a question that does drive me nuts, which is in the French-language services surveys that were sent out. Some LHINs ask us how many French-speaking board members we have, and some ask us how many francophone board members we have. They're probably reporting that as the same statistic, but those are two different questions, and they mean two different things.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do appreciate your input, and I'm sure it will be beneficial to us.

HURON PERTH HEALTHCARE ALLIANCE

The Chair (Mr. Ernie Hardeman): Our next delegation is Huron Perth Healthcare Alliance: Andrew Williams, president and chief executive officer. Thank you very much for coming in.

As you're setting up, we first of all thank you for taking the time to come in here today. Secondly, we'd just point out that you have 15 minutes to make your presentation. You can use all or any of that time in your presentation. For anything that's left over, we will have questions and comments from the committee members. With that, thank you very much, and the next 15 minutes are yours.

Mr. Andrew Williams: Thank you very much. Mr. Chairman and committee members, it's a pleasure to be here. I want to acknowledge the great work that you're doing on this file. I don't think there's a more important issue to Ontarians and Canadians than health care, so it's greatly appreciated, the effort and energy you're taking in this.

As was pointed out, my name is Andrew Williams. I'm the president and CEO of the Huron Perth Healthcare Alliance, and I'm here to speak to a number of issues as they relate to the LHIN and our relationship.

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I'm starting with a picture of a couple of dogs, not because I think the system has gone to the dogs, but because to me this reflects what health care is all about. If you've seen this before, this is Lily and Maddison. Lily lost her eyes, and Maddison became her eyes. For five years, everywhere they went, she was her eyes. To me, that speaks to what health care should be about: caring, compassionate support based on individual needs—and I think this is a very powerful image for that.

What I will do—just a bit about who we are—is talk quickly about some of the selected patient-care improvements that LHIN leadership has led to. I think that if we're not talking about patient-care improvements, then we're not at the right table. When I talk about LHIN leadership—the LHIN in the southwest engages all of the stakeholders and brings us together, so the solutions that we come up with are systems solutions, not driven by any one particular organization. I'll talk about some of the specific activities that we're involved in, and then a few recommendations, as was requested by the committee.

We represent four hospitals in southwest Ontario, in Clinton, St. Marys, Seaforth and Stratford. We came together 10 years ago. We were four individual organizations with four separate boards. Now we're one board, one organization. Geographically, if you know the area, Clinton and Stratford are about 55 kilometres apart, so that gives you some context. The LHIN breaks itself down into three planning regions: the north, the central and the south. We are the central region.

If you've been in our area in the last few weeks, this is probably the road sign that you've seen most often, because most of our roads have actually been closed due to snow. It adds a different perspective when you're dealing with health care issues and accessibility in communities like ours, where conditions and access can be such a big issue to address.

A bit about the alliance: We were formed in 2003. We're a voluntary arrangement; we weren't forced to come together. We have one board, with about 1,200

staff; 150 professional staff, those being physicians, midwives, extended-class nurses and dentists; and about 500 volunteers.

I'll tell you one thing: Our health care system wouldn't be what it is today if it weren't for our volunteers.

We have separate foundations and auxiliaries. We have a budget of about \$126 million. We have local advisory committees that operate in each of our hospital communities to support the board in decision-making.

From an activity point of view, we had about 58,000 emergency visits last year, over 15,000 surgeries, 86,000 imaging exams, and over 28,000 patient days. If you followed any of the patient satisfaction releases over the last little while, two of our sites were the top performers in the hospital system in "likely to recommend," in acute care services, and overall care in emergency departments. We take patient care, patient safety and patient satisfaction very, very seriously, as one of our top drivers.

Our vision as an organization is to improve the health and well-being of the people that we serve by leading the development of a sustainable, fully integrated rural health system. I think the word "integrated" is key for this discussion, because that's really what the LHINs were introduced to do: to help integrate the system, to advance patient care.

The guiding principles that we operate under are very simple: people, performance and partnerships. We feel that if we can support our people, improve our performance, and develop strong partnerships, we're going to meet our local mandates in our communities across Huron and Perth.

From a selected patient-care improvement perspective—some of these you've heard about, but I think it's important to remind ourselves, from a provider's perspective. The first is the one-number access to care that Michael Sharpe talked about a few minutes ago. The number one stress on primary care providers in small hospitals in rural communities is not knowing where you're going to send a critically ill patient at 3 in the morning. If you talk to anybody coming in, they will say that's the one thing that keeps them up at night: not feeling confident that their patients are going to get the care they need when they need it.

Introduction of things like this have elevated our ability to sustain recruitment/retention and have really improved our ability to provide high-quality care, and it's only through a system focus that you can do this.

Sandra talked about Home First. We have seen Home First implemented across most of our LHIN and the impact that it has on patient flow. Our ability to move patients from the ERs into beds that would otherwise have been occupied by patients waiting for long-term care has been significant. Again, help improve patient care through a system focus driven by the LHIN.

Timely access for hip fractures: another example of a project that was engaging all of our providers around how you get people into the OR within 48 hours after a hip fracture, whether you have access to orthopedics in

that site or not. If you look at the data, it's a concern. After 48 hours, patient outcomes become more serious; they have comorbid conditions. Through the LHIN leadership, we focused on this issue, and we've been able to bring our times down significantly. So, regardless of where you end up in this LHIN, you're going to get access to an orthopedic surgeon in some hospital that provides the service.

Overall wait times: We've seen a significant reduction. Rob talked about MRI wait times that have come down in the last number of years. We're focusing on CT, on hip and knees, on cancer surgeries, on cataracts. All have been really positively addressed by a system focus, rather than individual sites looking at their own needs—stepping back, looking at what the needs of the population are as driven by a more broad and robust assessment.

If you live in rural communities, you'll know transportation is a challenge. It's a challenge in any community, obviously, but in rural areas it can be doubly difficult for people. Our LHIN was the first LHIN in the province to standardize patient transport guidelines. We have gone out and we've issued an RFP and have gone to one carrier across the entire LHIN for patient transport. That does two things: Number one, it moves your patients around in a coordinated way, but more importantly, it sets quality standards in place that you can then hold the provider accountable to. To us, that is an absolute must, with the amount of time we're using these services to move patients around. It's not like a large, urban centre where you may have everything in one hospital. We don't, in most of our hospitals in rural Ontario, so we have to move them to a different hospital for an MRI or a CT or whatever the test might be. Having this sort of service is key.

Physician engagement: You've heard a lot about that. You cannot advance health care without engaging the players, and physician leadership is hugely important. Through our primary care network, through the critical care network, through the mental health network, all have really assisted us significantly.

The last area is just to highlight some of the projects that are ongoing now focusing on cataracts, endoscopy, stroke and mental health access through ERs—all things, again, that help improve patient care.

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In our particular case, we've put some pretty contentious suggestions on the table and we've stood in front of community forums with 500 to 600 people, all who have opinions on what we should or shouldn't do, and we've really taken it seriously. We know that to sustain and grow health care, you cannot look at it through the same lens today or that same lens that we've set up today. We have to look at things differently. We have to realign services. We have to reconfigure emergency departments, for example. And through the endorsement and support of the LHIN, we've been able to put really comprehensive engagement processes together that allow people to contribute to those processes in a positive, productive way to help us advance our health care needs.

Mental health integration: We've brought six disparate providers in our region together to work in a coordinated fashion to meet the needs of the mental health patients. If someone were to ask me what is the most important area of health care right now that we're not dealing with properly, it's mental health. We have to do better, and we're seeing some real advances in our area through this leadership, and it's going to continue.

Cataract surgery consolidation and long-term-care partnerships with our organization: We have not only seen system improvements to care, but within our own organization we've worked very, very closely with the LHIN and have been able to advance a number of things locally that we feel will improve health care.

This slide is a picture I took in Plaster Rock. I'm sure many of you don't know where Plaster Rock is, but it's on your way to PEI in northern New Brunswick. The sign reads, "Eight-hour ER. No lab. No X-ray. No deaths after 5:00."

We know that health care is remarkably emotional. Regardless of what changes you might put forward, there will be opinions on it. It is really key, in my view, to make sure that you are engaging all the players in the dialogue, but you cannot avoid making decisions, often difficult ones. LHINs need to be there and they have been here locally, standing beside the providers and assisting us in doing that.

If we look to the road ahead and a few recommendations: a couple of things, and again, things you've heard about already. Continue to build on the strengths of the LHIN model. Structural change on a system is huge. The transition from the district health council regional office model to LHINs took a lot of time for the system to understand the new way to deal with issues. Structural reform is massive, so we would say: Build on the strengths of what's working in the LHIN model. I'm sure you've seen very different approaches across the province. There are a lot of great ones, and our LHIN, in this area, I believe is a shining star that should be emulated across the province.

Maximize system planning and integration by including all health service providers under the planning umbrella of the LHINs. We've heard about the physicians and primary care providers. In rural communities, the primary care physician is much more aligned with the local health care system than in a large urban centre. In our communities, the physician not only provides family practice, they look after the long-term-care facility, they look after the emergency department, they look after our in-patients. Having a coordinated approach to planning is vitally important for us as we move forward and look at changes.

Clarifying roles and responsibilities across the system between the ministry, the LHIN and health service providers, I think, is something that needs to be addressed. A really good example is, right now, we have capital projects and we're dealing with financial reconciliation with the ministry. We deal with the LHIN on most of our operating budgets. We deal with Cancer Care Ontario on

some of our wait times. So we have different groups that we have to go to and are held accountable to. It makes it confusing at times, and I think there are some ways we can improve in that area, all based on improving quality, improving access and improving value for money.

Identifying and removing legislative barriers to health system integration, I think, from a provider point of view, would be beneficial. As we look at the different sectors and trying to integrate, whether it's acute care, long-term care, primary care—it doesn't matter which sector—there are legislative issues that often cause us not to look at opportunities, and I think there are some ways we can help in that area.

Enhancing public awareness around our health care system I think is a very important role for the LHIN to play, for the government to play and for health service providers to play. As I mentioned earlier, far too often, health care planning is driven by emotion, and we need to ensure that we have an engaged public who are aware of what the system can do, how they can influence the system and what changes we need to make to move forward.

The last recommendation that we've included here is maintaining and strengthening local governance, including moving away from order-in-council LHIN board appointments. There's a lot of good literature out there on best practice governance, and I think there's a real opportunity to further strengthen from that vantage point.

This slide—I really like this one. "There are only two things I don't like: change and the way things are." Change we must, whether we like it or not, but in a thoughtful, system-wide manner, with an organization that can help guide and pull the various players together with an eye to the future.

The future is what we're all about. These are my two boys. They're a little older today. I always like to remind myself that part of my role as a health leader is to make sure that when they're my age, they continue to have access to the great health care that I do. That won't happen unless we move the system forward in a coordinated fashion through regional planning in areas like ours.

I'm happy to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, and we have about two and half or three minutes left. It goes to the government: Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for your presentation. I just want to focus a little bit, if we can, on your recommendations. Number 4: identify and remove legislative barriers to health system integration. What exactly are you getting at there?

Mr. Andrew Williams: The Public Sector Labour Relations Transition Act is in place and has to be adhered to in any type of integration. But if we were to take different sectors and try to merge or align them in a way that we think will improve care, there's significant disruption because of the legislative requirements that we have to follow, so I think there are ways that we can help smooth that out to make integration a bit more accessible to organizations, largely financial—significant financial

impact. It's not necessary, but would happen under the current legislation.

Ms. Helena Jaczek: So in other words, if you integrated two different bargaining units with different salary levels, you would have to go to the top.

Mr. Andrew Williams: You automatically jump to the highest, regardless of what that might be.

Ms. Helena Jaczek: Okay. And if we could quickly go to number 6: instead of order-in-council LHIN board appointments—what are you getting at there?

Mr. Andrew Williams: More locally driven within each LHIN; obviously being driven by some clear principles around geographic representation, but being able to, in essence, control the appointment process within the LHIN structure, not having to go outside that to receive approvals for the appointments.

Ms. Helena Jaczek: So sort of a nomination committee of the board that would look more, perhaps, at the way district health councils—

Mr. Andrew Williams: Yes, absolutely. We have, in our situation, a skills-based board that has a primary filter of geography, just given the four hospitals that we have. But we look at the different requirements. They do that in the LHIN, but they still have to go outside of our region to have endorsement. I think if it's local, it's more transparent and it would be more acceptable.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, and particularly the start and the finish. I think that really says it all.

LONDON HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presentation is the London Health Coalition: Peter Bergmanis, co-chairperson, and Jeff Hanks, co-chairperson.

Mr. Peter Bergmanis: Thank you, Mr. Chair. My apologies; my co-chair will not be here, so I'll commence on my own.

The Chair (Mr. Ernie Hardeman): It's a good thing we got the best of the two, right?

Mr. Peter Bergmanis: That's what I would say. I'll have to also add another apology: I'm probably going to have to apologize to the presenter ahead of me because I'm going to contradict him in many respects of what his presentation was. But I do agree with one thing: that we are all about public engagement when this process is being laid out before us.

I'll just get to the presentation and explain that our organization, the London Health Coalition, is a constituent chapter of the Ontario Health Coalition, with a primary goal to protect and to improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice, as well as the five principles of the Canada Health Act: universality, comprehensiveness, portability, accessibility and public

administration. We are a non-partisan public interest activist coalition and network.

Some of our key issues—and, again, this might contradict what our previous presenter had stated—are that we do see a lack of democracy in the community efforts around LHINs' development. The public health system belongs in the democratic arena. This includes meaningful public input, public involvement in the evaluation of decisions, access to documents and information, the right to appeal, and representational governance. None of these apparently exist in the local health integration networks as we speak today.

With little public desire, the LHINs were introduced by the province in 2006 to coordinate health care on a local basis. The province was subsequently divided into 14 LHINs for this purpose. Although responsible for disbursement of public funds to medical service providers, the LHINs' terms of reference never enshrined the principles of the Canada Health Act: the aforementioned universality, comprehensiveness, accessibility and public administration.

Although required by the Local Health Systems Integration Act, 2006, to achieve and sustain high-quality community engagement and to improve accountability and transparency to the public, in practice, community engagement is little more than a public relations exercise designed to persuade rather than truly involve, serving to antagonize communities at great expense to the public purse.

Misalignment between capital planning and LHIN service cuts has served to discredit the entire enterprise. The London Health Coalition's own experience with the South West LHIN has been a recognition of top-down management style, with local board members faced with the enactment of detrimental Ministry of Health and Long-Term Care pre-ordained decisions.

For its part, the Ontario Health Coalition has identified poor, inconsistent and wasteful processes, such as failure to make integration decisions when services are being transferred, for instance, in the Ottawa situation, Thunder Bay long-term-care beds etc.; inconsistent and poor access to information, with requests for documents pertaining to service planning decisions routinely going unanswered; and no apparent evaluation of the decisions made.

Moreover, needs-based planning is non-existent. The core function of our public health system should be to measure and meet population need. In reality, capacity planning has not been performed, not even sectorally, for almost 20 years.

Health system capacity planning must be done, and it should be based on evidence-based assessments. To date, LHINs have cut, closed and facilitated or forced off-loading of needed health care services, particularly in the hospital services, in regions all across the province. Health care planning has been completely divorced from the population need.

Amalgamated hospitals are a problematic situation under the system. They are not considered entities under

the act, and, therefore, whole hospitals for entire communities are treated as departments of larger hospitals and subject to disproportionate cuts and closures.

Since 1990, Ontario has aggressively cut more hospital beds than any other jurisdiction in the country. That would be approximately 18,500.

By the end of 2012, Ontario merged or shut 87 hospitals. Yet, in a process that cost nearly \$1.3 billion in the London area alone, the Ministry of Health and Long-Term Care confesses to neither tracking the money spent nor assessing the effects of restructuring and mergers on hospitals.

The city of London is a regional medical hub. The chaos of hospital restructuring has seen the South Street campus closed and University and Victoria hospitals merged, not to mention Parkwood Hospital, St. Mary's Hospital, Marian Villa, London Psychiatric Hospital, St. Thomas Psychiatric Hospital and St. Joseph's Hospital all amalgamated into one entity. From the wreckage, two health care conglomerates have emerged: the London Health Sciences Centre and St. Joseph's Health Care.

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Regrettably, over the course of the past two decades, the municipality has lost two thirds of its acute care beds and has suffered the loss of one of its emergency departments. Obstetrics has been cut in half, as has heart surgery. The city's intensive care units have shrunk from three to two. Hip and knee replacement is only performed at the London Health Sciences Centre. Through hospital restructuring and extensive program transfers, St. Joseph's has been transformed from an acute care facility to an ambulatory care centre. This dramatic decline in available hospital services has transpired while the city's population has grown.

In order to achieve provincially mandated balanced budgets, both hospitals have cut staff and services. In the most recent round of austerity-induced measures, St. Joe's has been forced to reduce medical diagnostic imaging hours and operating room time and to institute two weeks of cataract suite closures. On weekends, the remaining surgical floor of the hospital must contend with the disruptive transfer of patients from the nursing unit to the PACU and back again so as to save on costs associated with operating a surgical unit seven days a week.

Also, with the closure of St. Joe's morgue, pickup of amputated limbs is contracted out to Hoffmans Patient Transfer, a private service provider. The limb rests in a garbage bag-lined box in a dirty utility room until the driver arrives to pick it up.

Naturally, due to the cutbacks, wait times for diagnostic imaging and cataract surgery are creeping up. The number of cataract surgeries the hospital provides has fallen to 4,171 this year, from a peak of 5,126 three years ago—a 20% reduction. Each month, the waiting lists grow, and by the end of 2013, wait times for cataract surgery had risen from 153 days to 230 days.

The closed St. Joe's ER department has reinvented itself as an urgent care centre, but is under-resourced and

plagued by staffing challenges. Originally operating from 8 until 10 on a daily basis, St. Joe's can now only muster an 8-until-6 operating time. Urgent care is intended for non-life-threatening conditions, but faced with long waits at the two remaining London ERs, patients are crowding the urgent care waiting room. The situation was recently exacerbated by the locally reported 140% patient capacity rate at the London Health Sciences Centre. LHSC was placed in a position of requesting citizens to stay away unless absolutely necessary.

Other deficit-busting measures implemented at St. Joe's have included closing a St. Thomas-based job-training workshop that helped 80 people in the mental health program, redesigning an intensive four-week fibromyalgia management program that helped 108 people a year, and the closure of an aquatic-therapy program, affecting about 400, many of them women in their 70s and 80s. They must now find relief elsewhere and quite likely will face personal out-of-pocket expenses to do so.

LHSC, the larger of the two health care conglomerates, for its part, is meeting fiscal constraints through reduced nursing hours, earlier patient discharges and rationing of OR time. Clearly, London and region have undergone serious cuts to hospital-based services without regard for patient risk. There has been no special treatment of cornerstone services and no trauma planning, the kind of care which simply cannot be provided outside of a hospital setting. With another anticipated flat-lined fiscal year approaching, the likelihood of devolving more hospital-based services into the hands of for-profit providers appears certain.

This is where we approach privatization. Although the Wynne government has recently publicly chastised the federal Conservative government for abandoning its obligations to provide services of national interest, Ontario's Liberal government has announced plans to bring in new regulations to cut services from our community-based hospitals and outsource them to private clinics. What social spending priority could be more in the national interest than the preservation of medicare?

Private health care, including private health insurance, is unfair and unsustainable. This is why Canadians opted for universal medicare in the 1960s. Not only is it a fairer and more just system of providing health care based on need; it is more sustainable.

Most of the outpatient surgery in Canada is done in non-profit hospitals, but for-profit clinics are waging an aggressive campaign to capture a larger share of the health care market. Most peer-reviewed studies have shown that publicly funded hospitals are much more efficient and, compared to their for-profit counterparts, provide a higher quality of care at a much lower cost, both in terms of mortality rates and price. In spite of such compelling evidence, some provinces, including ours, are providing space and opportunity to clinic owners.

Cuts forced under the LHIN system of accountability agreements and service integration have transferred services such as physiotherapy, endoscopy, cataracts,

colonoscopies, chronic care and long-term care from public, non-profit entities to private, for-profit entities. Many of these service transfers have been made without the required LHIN integration decisions.

Though the legislation prohibits the minister from transferring services from non- to for-profits, it allows LHINs to do so. Moreover, the legislation prohibits the forced mergers, closures and dissolutions of for-profits but gives extraordinary powers to enable the minister to force amalgamations, closures and dissolution of non-profits.

Oddly, the Liberal government's vision for health care does not include community hospitals. Instead, the government wants to take services that patients need, like MRIs, CAT scans, and cataract and day surgeries, out of local hospitals and outsource them to private clinics.

We, as Canadians, live next to the largest for-profit providers in the world. The United States is home to massive profit-seeking hospital conglomerates and companies that covet access to our public subsidies for health care. These corporations, and some home-grown ones also, are lobbying the government and funding campaigns to outsource our community hospital services.

In the model of private clinics proposed by the Ontario government, there is no legislated protection against for-profit privatization. In fact, the government expressly intends to establish private clinics outside of the Public Hospitals Act, and therefore without the protections against privatization that exist within the framework of the Public Hospitals Act.

The Wynne government's single-minded plan to gut public hospital services and contract them to private clinics bears close resemblance to the British government's experiments with contracting of public hospital services to private clinics called independent sector treatment centres. In the UK and in other jurisdictions, multiple studies report lighter caseloads and evidence of "cream-skimming" by private clinics, leaving the more expensive and heavier caseloads to the public, non-profit hospitals while depriving hospitals of needed resources, both human and financial, to treat them.

The health coalition's own research into private clinics across Canada revealed that the cost of procedures was considerably higher in private clinics than in public hospitals. These findings echo the Auditor General's report on his own audit of the Ontario system.

A case in point is that we have our own clinic here in Ontario, in London, which is Medpoint. The Medpoint clinics were established here five years ago under the ownership of Mr. Hanham and his co-owner physician wife, Dr. Murchison. They have expanded twice, doubling their space while adding a pediatric facility in the Byron area. The staff has grown to 28 employees from two full-time and three part-time. They're looking to move into the Ottawa region. They have basically provided services under OHIP, but they also contract out services at a fee of \$1,800 to well-heeled clients who are willing to pay for that, and to corporate clients. Unfortunately, this also means that it blurs the lines between

Canada's public and private delivery of health care. It also offends our sensibilities regarding access to care, one based on need rather than wealth. It is all the more galling that corporate clients can claim their membership fees as a business expense, thereby enjoying the subsidization of Canada's progressive tax system to jump the health care queue.

Unchecked, the introduction of for-profits raises questions of ethics. Does a physician-owned facility bear allegiance first to patients or to shareholders? What about quality and safety concerns? In a recent well-publicized case, an Ottawa area private endoscopy clinic was found to have failed to properly sterilize equipment, resulting in 6,800 patients being notified that they should be tested for HIV and hepatitis B and C. In a 2007 case, it was revealed that 13% of colonoscopies conducted in a private clinic were not completed because the scope had failed to reach the colon. Research also found that there are more missed cancers in private clinics that do diagnostic testing than in hospitals. The privately contracted radioactive isotope scandal touched the lives of cancer patients here in London, as well, at the LHSC.

Of course, finally, the ultimate threat posed by for-profits within Canada's public system is the onslaught of corporate challenges to medicare through international trade agreements. Such is the potential if current destabilizing government initiatives remain in place.

Queen's Park has the opportunity to create a comprehensive system of care driven by the needs of patients and their communities. LHINs should be at the forefront of the defence of medicare and not an unwitting instrument of its destruction.

I thank you for your time.

1650

The Chair (Mr. Ernie Hardeman): Two seconds, and it was 15 minutes up. Thank you very much for timing it out perfectly, and we thank you very much for your presentation.

Mr. Peter Bergmanis: Thank you.

MS. SHIRLEY BIRO

The Chair (Mr. Ernie Hardeman): Our next presentation is Shirley Biro. Welcome, Shirley. It's good to see you again. As with previous presenters, you have 15 minutes to make your presentation, and you can use any or all of that time. With any time you don't use, we will have questions and comments from our committee. With that, Shirley, welcome, and the next 15 minutes are yours.

Ms. Shirley Biro: Mr. Chairman and committee members, my name is Shirley Biro, and I'm a community representative at this table today. It is my pleasure to come before you today and share my thoughts about the direction of primary care in Ontario and the local health integration networks.

Since 1997, I have been involved at the local level with strategies to enhance the care of residents in my community. I am a retired registered nurse, retiring in

2003, and have been a community volunteer on many health-related committees such as the Elgin elder abuse resource committee. I'm a member of the Elgin Hospice Palliative Care Collaborative, the Elgin stroke working group and the southwest elder abuse network. I chair the East Elgin Family Health Team, and I recently retired from the Middlesex-Elgin VON community board of directors. I've also just recently been invited to the South West LHIN hospice palliative care leadership committee as a community representative. And I'm very proud to be a client representative on the South West Primary Care Network, with all those doctors.

The health of my community and other communities is of utmost importance, and if I can make any small difference to the health and well-being of persons in need, that is my goal.

In 2006, I had the privilege to be a community member of the strategic advisory group of the South West LHIN, which brought forward the first Integrated Health Service Plan. Recently, I've been a member of the Health System Leadership Council as a community representative again. This leadership council brought system leaders together from all sectors and geography across the South West LHIN to provide advice to the South West leadership on our health system responsibilities.

During this time frame, I have seen how the leadership from the South West LHIN has brought fiscal accountability to those organizations of which they are the funders.

There is now evidence of partnerships and linkages between organizations that can only be a benefit to those in the community being served, as well as having cost-effectiveness.

We are in a time of change in health care delivery, and the South West LHIN has been a leader in this area. We can no longer be reactive in the delivery of health care. Health promotion and disease prevention is where we have to be at this time, and the LHINs are poised to ensure that these strategies are implemented and direct funding to the areas which can provide the highest level of these services with the greatest possible outcomes for the individuals participating.

An example is the partnership between the Victorian Order of Nurses and the Parkinson's organization, as a pilot project, to provide an exercise program called Seniors Maintaining Active Roles Together, specially designed for persons in various stages of Parkinson's disease. The results of this exercise program have been effective and dramatic.

Now, since that pilot, the funding has come to the Victorian Order of Nurses through the South West LHIN to expand their SMART programs into long-term-care homes and the community. Please note that these SMART classes are led by trained volunteers. Organizations sometimes cannot exist without their volunteer base.

We have adult day programs and supportive housing to help seniors stay at home for as long as possible, and also support for the caregivers as well.

These are just two examples of how the South West LHIN has supported strategies to improve the health and well-being of the communities which they serve.

My recommendation to this committee is that you implement the recommendations in chapter 5 of the Drummond report immediately. We are already implementing elements of that report under such strategies as Access to Care, Home at Last and Home First. Pharmacists are being proactive and accountable through the interview process. Everyone is allowed 30 minutes per year for a medication review with the clients about their medications.

The report also outlines even more responsibilities for pharmacists in the prescribing of medications. The South West Primary Care Network is working with physicians in this province, as Dr. Annis alluded to, to assist in the implementation of open-access scheduling and the encouragement of technology through OTN and electronic medical records. These are only two examples of what the primary care network is doing.

The LHIN is taking a leadership role by the actions in their accountability agreements that relate to those organizations which receive funding through the LHIN. As we move forward in defining measurable outcomes, we will be able to demonstrate the best-practice use of funds and also identify gaps, if they still exist.

The LHIN leadership teams from across the province meet on a regular basis to network and share best practices. How can you not support an organization who can demonstrate the leadership and fiscal prowess to provide the highest quality of care to the citizens of this province in a fiscally responsible way?

If I could seek out a strategy for the LHINs to continue to push forward, it would be continuous education of the public. To quote Don Drummond, "An informed public is essential to the success of the reforms."

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for that presentation.

We have about eight minutes left, so that's about two and a half minutes per caucus. We'll start with the third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: You're one of the few community representatives, so I'm glad to hear your presentation. It's nice to hear a perspective from someone just volunteering and working in the LHIN, working on boards and in community organizations.

I wasn't going to ask a question, but I have a question. You had mentioned that volunteers deliver seniors' exercise programs.

Ms. Shirley Biro: Through the VON. Their SMART program is taught by trained volunteers.

Ms. Teresa J. Armstrong: How do the volunteers get trained? Who trains them?

Ms. Shirley Biro: They have a train-the-trainer program, where an individual is taught the exercises, and then they in turn teach it to someone else.

Ms. Teresa J. Armstrong: Okay. Thank you very much for coming today.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much for coming. As has been said, it's great to hear from a community member and someone who has been so involved. I'm a physician; you're a nurse, and I have every confidence that you're keeping the primary care network in order.

Ms. Shirley Biro: It's difficult.

Ms. Helena Jaczek: I'm sure it is.

It's clear that you're a fan of the LHIN structure, particularly because of what you know the South West LHIN has been doing. You've talked about educating the public. We have heard, as has been said before, that in some areas people are just not aware. You're a great community representative. Is there a role—centrally, perhaps—for the ministry to make people more aware? Should it all be local? Should it be using the right radio station in a community? What can we really do to get people more involved?

Ms. Shirley Biro: The best way that I know of is by people sharing their positive outcomes—people talking to people. That's how I hear what works and what doesn't work. I've experienced the system; I know it can work. I have an edge, because I've been with the development of the system, but I always advocate for what works and try to listen to what went wrong and explain.

You've mentioned the only avenues that I really know of—the local radio stations. Everyone doesn't have a computer, so you have to use newspapers, flyers, bulletin boards and things like that to get the word out about meetings to inform the public. By now, the public have all heard about the LHIN, but they don't know exactly what it is or what it does. All they know is that when they're sick, they need a doctor.

So I don't have a magic bullet to say, "This is how we're going to do it," but we can't give up talking about it and explaining about it, because if we don't go forward, we're going backwards. That being said, we have to quit doing what we did for the last 50, 75, who knows how many years, and move into the new delivery system of health care. It won't be easy. We have an increasing element of seniors coming on board with the population growth in that area, so we've got to address access as we all get older. I'm in that category.

That being said, there are so many elements that we have to look at differently, and not just the absence of disease, Dr. Jaczek. We have to look at all the determinants of health. I see that in the conversations at the tables that I sit in, that we are looking at the social determinants of health at the education level, at the economic level. How can people be healthy if they don't have the funds to buy the proper food? I even question the food bank: "When you hand out food to people, do you give them education on, 'This is what you're getting and this is what you can do with it?'"—and they are. That small element is helping, as far as the health of the community is concerned. But it's a big challenge. Any time you have change, you have resistance and you have the hiccups that go with it. So we have to keep moving forward and

never give up, because it has to be done. We have to take a look at doing things differently.

1700

Ms. Helena Jaczek: Thank you for your words of wisdom.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you, Chair, and thank you, Ms. Biro, for being here today and for your presentation, but also the significant contribution that you've made to improving health care in your community, both as an RN for many years and now as a community representative. We really need people like you to continue to be engaged to help us transform the system.

I agree with you: We can't keep doing things the same old way. The challenge for all of us, including us as politicians, is: How do we have that dialogue with members of the public? How do we talk about the new ways of doing things in a way that it isn't going to frighten people? Because I think right now, people are hearing that our system isn't sustainable, that we can't keep doing things the same old way, but they're not really hearing answers from us about how we should change the system. I'd really be interested in your comments about how you would propose that we open up that conversation with the public to have a full discussion about what we need to do to make the changes in our system.

Ms. Shirley Biro: Well, my first thought would be the physicians: I think physicians are the champions of the system moving forward, in the sense that everyone trusts their physician. And as I mentioned in my presentation, health promotion and disease prevention is where we have to start. We have to work with the public health and start with the children, and build from there. Just a classic example is, when they started the anti-smoking dialogue years ago, little children would come home and say, "Daddy, you're not supposed to smoke anymore, because I heard that in school." So we need to start to build a healthier society; that's where we need to start.

I really believe that the physicians can be really key players because, years ago, if you went in and your doctor found you had high blood pressure—this is my example—he didn't tell you to go home and watch your salt and start thinking about losing 20 pounds and going for a walk for 30 minutes a day. He just gave you pills and you went on your merry way, and you came back for another visit which was billed to OHIP. Today, you don't need to do that. You don't need to see your doctor for that kind of simple thing. If we start focusing on health promotion and disease prevention, we're going to grow a healthier society.

The problem is that there are all of us in my era right now that we have to deal with, with multiple morbidities, and we have to treat those people. But we're starting in family health teams, having a team of collaborative health care deliverers who will work together to try to help these people have the highest quality of life for the life that they have left. I guess I would have to say that to move this forward, we have to work together as a team.

But it's not entirely resting on the shoulders of the physicians. I think we have to share the job with your nurse practitioners and your nurses and your dietitians and your social workers.

The other thing I want to comment to you, since I have this opportunity, is that I'm happy to see that primary care is embracing mental health care now. Before, it was mental health care here and primary health care there, and now we're bringing it all together, and that is such a revelation.

The Chair (Mr. Ernie Hardeman): Shirley, I'm really glad that you have had this opportunity too, and I use the word "had" because the time is up.

Ms. Shirley Biro: I know. I could go on forever.

The Chair (Mr. Ernie Hardeman): Thank you very much for taking the time to come here and speak to us today. It's much appreciated, and it's particularly nice to hear from a—

Ms. Shirley Biro: I'm a consumer.

The Chair (Mr. Ernie Hardeman): —a community-minded person who wants to make the system better. Thank you very much.

Ms. Shirley Biro: I hope you have good luck with the changes.

CANADIAN MENTAL HEALTH ASSOCIATION, ELGIN BRANCH

The Chair (Mr. Ernie Hardeman): Our next presenter is the Canadian Mental Health Association, Elgin Branch: Heather DeBruyn, executive director. Welcome, Heather. Thank you very much for being here. As with everyone else, you have 15 minutes to make your presentation. You can use all or part of it, and any part that's left over we will share with the committee for questions. The next 15 minutes are yours.

Ms. Heather DeBruyn: Thank you. I know it's very difficult going last, and you guys have been going all morning and all afternoon.

Before I actually do my presentation, I just want to clarify a point that was raised by the gentleman before Shirley about the closure of 80 vocational program spots in St. Thomas. I am in St. Thomas; this is what we do. That's part of the whole divestment piece with regional mental health care. We worked collaboratively for many years—over 10 years—to come up with comprehensive plans on what happens when those hospital programs close, and I can tell you, with that particular closure, a business plan was derived between Canadian Mental Health and Goodwill Industries to come up with a best-practices program around life skills, living life to the fullest, self-help programs to help those individuals who can get into competitive employment get competitive employment, and, for those individuals who need ongoing support, to get them ongoing support.

I just wanted to clarify that part, because it's not 80 things gone. It's 80 things gone from a hospital, but it has created space for almost 200 people in the community. So I'll just say that bit.

The Chair (Mr. Ernie Hardeman): Thank you very much for that.

Ms. Heather DeBruyn: What I have brought with me is actually the Jim Whaley report with regard to mental health and addictions and where investments needed to go. I wanted to bring this because this, to me, typifies how the process works.

1710

We have had a mental health and addictions committee in St. Thomas-Elgin for 15 or 20 years, and we have sat around and looked at gaps in services and we've done all of the efficiencies that we could possibly do. We've got all the partners, including the police, the hospital, VON—everybody and sundry—as have all these other communities across our LHIN.

When the LHIN came into being, they helped us create a coalition of all of those mental health and addictions networks so that we could look at themes of needs across the whole LHIN. What happened is that we were able to get the LHIN to hire a consultant to work with all of the local communities, to come to our committee meetings and talk about what the actual gaps in services were. We were a little worried about just investing monies without any expectation of outcomes. Both Canadian Mental Health and other community mental health organizations and our consumer groups—we all need more money, we all want to do more work, but we wanted to be able to demonstrate that we had some outcomes for the investments and that those were the outcomes that were intended with the investments.

The LHIN was able to come up with some money to hire a consultant who came to all of our local committees and talked to all of our regional people and then come up with a report on what was working well in what areas, how many staff that took, and how many clients you could anticipate that you would be able to help with that investment. I can tell you that over the last couple of years there has been strategic investment from the LHIN to go into what our report turned out as the needs, and now, after those investments are done, there are other things that are emerging in mental health and addictions, especially with regard to interactions with the law and court support and those kinds of things.

The LHIN again has hired Mr. Whaley to come back and do a refresh of this report so that we can look at: Did we meet the things that we thought we would meet with this investment? What were we not able to predict as emerging needs? And where might the future investments need to go?

I think it gives you a really good example of the local issues and concerns, being able to voice those, to look at the similarities across our LHINs so that we do have consistency with regard to what services are provided, and also what are best practices so that there is strategic investment and so that we can have outcomes that are going to mean that we are not in the emergency room, we're not having unnecessary hospitalizations and we're not having unnecessary incarcerations. I just wanted to bring that to you.

As somebody had mentioned earlier, if you could say how the system is supposed to work and what that looks like—I would suggest, if you look at this documentation and how local agencies were engaged and then rolled up to come and have an understanding of the whole LHIN-wide issues—this would be a good example of how I believe the system should work for all specialty groups.

The Chair (Mr. Ernie Hardeman): Thank you. That's the end of your—

Ms. Heather DeBruyn: Yes.

The Chair (Mr. Ernie Hardeman): Okay. Then we have about 10 minutes left for questions and comments. We start with the government side first: Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for coming in. Both Ms. Elliott and I were on the Select Committee on Mental Health and Addictions and had a very interesting visit to St. Thomas and learned a lot about what was necessary, in terms of the community supports. So, obviously, your organization has been totally involved in that consultation.

You feel that the LHIN has been a really important part of facilitating that type of discussion, the shift from institution to community and appropriate supports. Without the LHIN, do you think you would have had such a smooth transition, or at least a plan for a smooth transition?

Ms. Heather DeBruyn: I think what the LHIN does is it balances the playing field between institutions and community partners, so that when you actually come to the table, you feel like you're equals.

We're just a very small agency. We have 50 staff. We have—\$5 million is our budget, which used to be less than the deficit of the general hospital. So it's not a balanced playing field.

I've been with the Canadian Mental Health Association for 25 years, so I've been through the district health council days. The planning was great, but you would get to a standstill between the planning and the ability to implement.

What I have seen with the LHIN is that because they have staff that come to the committee levels, they can help you frame your need in a way that it aligns with what the goals are so that you can plan and implement and then evaluate. To me, it has helped make the divestment of regional mental health care smoother, and there's more communication with community partners.

Ms. Helena Jaczek: Are you, by any chance, part of this Health System Leadership Council?

Ms. Heather DeBruyn: The Health System Leadership Council has just wrapped up, but, yes, I was a part of the leadership council. I chair the mental health and addiction Elgin component, and I co-chair the Elgin health systems council. There are a lot of pieces—because we're local and we're small, there's a lot of accountability. But because you have LHIN representation and LHIN reports coming to your local committees, it helps keep people on track with moving the system forward.

Ms. Helena Jaczek: So would you have any recommendation in terms of improving the system as you have experienced it?

Ms. Heather DeBruyn: I think our LHIN, the South West LHIN—I've heard from my colleagues across the province. They don't necessarily have as much input into the changes that are made. I think this type of a process of engagement and implementation and evaluation is a very successful process.

The other recommendation would be around streamlining some of the reporting between the LHIN and the Ministry of Health, because there still is a difference in categories. In our LHIN, we've had a data quality committee, and we've consulted with the LHIN and the Ministry of Health at the same table. They do not necessarily agree on the interpretation of some of the pieces with regard to mental health and addictions. So streamlining some of those processes would be quite helpful.

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Ms. DeBruyn. I'm really pleased to hear that this LHIN is really making mental health a priority. I hope that the other LHINs are doing so as well because we have seen the personal devastation that it causes, as well as the financial costs to our criminal justice system and other systems that would be greatly reduced if we really put more resources into mental health supports and services. Thank you for a copy of this report. I look forward to reading it in due course, but you mentioned that Whaley and Co. has been re-engaged to revisit the report. I'm just wondering where they are in the process, what they found out so far and what the progress has been on implementing the recommendations contained in it.

Ms. Heather DeBruyn: So that's very brand new. January is when Jim Whaley has started to come back, but he actually comes right to our town, to our committee, and then engages—and we have a committee of about 20 people who represent all kinds of different sectors of service provision in our area, not just mental health, but we have the police there, we have the hospital, we have all kinds—violence against women and all of that. It's a pretty cohesive group. So he comes back and says, “Has this met your expectations of investment? Where do you see the gaps? Are we seeing the numbers that we expected? If we're not, what do you think that that looks like?” He has come and started the conversation and he will come back again, now that people have a chance to go back and review their data to see whether or not this has made changes, and what we see as the trends that might be coming, whether or not it be with the criminal justice system or decent, affordable housing, those kinds of things. It opens up the whole dialogue around that again.

Mrs. Christine Elliott: It's so important to measure those outcomes and identify best practices, so I'm very happy to see that that's moving forward. But, anecdotally, how do you feel that things are coming along?

Ms. Heather DeBruyn: I think that the pieces that we addressed in this report have been met quite nicely, and I think that there's evidence to support that it has been a

good investment. I think the emerging trends are going to be more with the criminal justice system, especially in Elgin county. We have had such a tremendous loss of employment that there are also some pieces that are coming out with poverty and some of the issues around poverty that we would not have been able to predict when this report was first being done.

The Chair (Mr. Ernie Hardeman): Ms. Sattler?

Ms. Peggy Sattler: Thank you very much for the report. It looks like it's going to be a very valuable resource for this process. I'm interested in hearing your perspective on the involvement of non-LHIN-funded agencies in the process that you undertook. One of the concerns that I've heard expressed about the LHIN model is the room that it provides, or doesn't provide, for non-LHIN-funded agencies that are obviously connected to the health care system, thinking specifically about some of the sectors you mentioned: violence against women, the justice system. Can you comment a little bit about your perspective on how that worked, involving those non-LHIN-funded agencies, and if you have some recommendations going forward on how LHINs could involve representatives from those other sectors that have an interest in the quality of health care delivery in the province?

Ms. Heather DeBruyn: Yes. There are two primary committees in St. Thomas that deal with health. One is the Health Services Council and one is the Mental Health and Addiction Network. We're small, so we only have three, four, or maybe five agencies that would be funded by the LHIN. The rest are all concerned citizens. Some of these committees were established before with the district health council and then we kept in place until the LHIN got up and running, because it's an area where we look at gaps in services and who can provide those services and how we can think out of the box to make sure that somebody doesn't end up falling through the cracks. That's the beauty of small community: There is a lot of accountability. For example, they city and their housing managers come and sit on the committees because they see a lot of emerging mental health and addictions issues in their housing and all of that. So our platforms that we already have in Elgin—and they are replicated across our LHINs with mental health and addictions networks—they already have non-LHIN-funded agencies that come to the table. They've been very good at partnering, because it is that whole spectrum of health that we're looking at. So we do have representation from doctors, for example, and from family health teams and all of those kinds of things to look at how we move the system forward, even though some of these other agencies are not under the umbrella of the LHINs—neither is the fire department and those kinds of things. And yet they become quite important, especially around hoarding and those kinds of things. We need them at the table because

it does end up interfering with the health of an individual. So we've been very good at bringing those around, and the LHIN has been very good about taking the voice from all of the players at the table.

Ms. Peggy Sattler: Is that model transferable, or does it work so well because of the very small community that you live in?

Ms. Heather DeBruyn: I believe it's transferable, because they have the same mental health networks and area-provided tables across our LHIN. London-Middlesex is huge, so it would have its own idiosyncrasies. But in all of our major areas, we do have both of those tables, and there is a forum to bring them back together with LHIN guidance. So the area-provided tables everywhere—we have teleconferences every couple of months to borrow what they have in other areas so we can replicate it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. We have reached the end of the road.

Ms. Heather DeBruyn: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here.

That concludes the deputations for this afternoon.

I have one announcement. The committee will remember that early this morning, there was some trouble with the equipment because of the temperature in the room. It turns out that the recording did not work for the first presenter. So we do not have the record and Hansard of the first presenter. That presenter did have a written presentation, so we'll have the written presentation. I just wanted to point out that I think there was one committee member who asked a question, so that will not be on the Hansard. It was one that you may be happy got lost, and it did.

Mr. Mike Colle: I have a question about equipment.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Will we have heat on the bus? I don't want to go to Windsor without heat in the bus.

The Chair (Mr. Ernie Hardeman): I will have to refer that to the bus driver.

Mr. Mike Colle: No, I think the Clerk should look into this. We shouldn't be going in this weather without heat on the bus.

The Chair (Mr. Ernie Hardeman): Yes, we'll check to make sure that there's heat on the bus. In my bus, I have heat.

Mr. Mike Colle: I know, but the Clerk should be assuring that we get safe transportation here. We can't go out in this cold without heat.

Interjections.

The Chair (Mr. Ernie Hardeman): The meeting stands adjourned.

The committee adjourned at 1723.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Thursday 30 January 2014

Journal des débats (Hansard)

Jeudi 30 janvier 2014

Standing Committee on Social Policy

Local Health System
Integration Act Review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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Hansard Reporting and Interpretation Services
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111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Thursday 30 January 2014

Jeudi 30 janvier 2014

The committee met at 0902 in the Holiday Inn and Suites Ambassador Bridge, Windsor.

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. I thank everyone for being here. The reason I did slam the gavel—I was going to wait on doing that until everyone was finished. There were very interesting conversations, but I realize that that may be when we were supposed to finish this meeting as opposed to when we started it, so I thought it was time to get started.

So, we'll say good morning and thank you very much for being here for the Thursday, January 30 meeting of the Standing Committee on Social Policy. We're here to review the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We're doing public consultations, travelling around the province, hearing from the people involved and getting their comments to help us write a report for the government to consider moving forward on the operations of the LHINs.

DR. GLENN BARTLETT

The Chair (Mr. Ernie Hardeman): Our first presentation this morning is the Windsor Essex Community Health Centre: Glenn Bartlett, executive director. Is Glenn here? No?

Interjection.

The Chair (Mr. Ernie Hardeman): I'm just told that Glenn is just arriving. Oh, there he is.

Mr. Mike Colle: Come on right up, Glenn.

The Chair (Mr. Ernie Hardeman): If you want to take a seat at the front of the table here. Thank you very much for being here. It's always a little tough being the first one in the morning, but anyway, I just wanted to point out to you, Glenn, that it's no tougher for the presenter than it is for those of us who have to be here on time. We do want to get started.

Thank you very much for coming in to make a presentation. We're looking forward to the presentation. You will have 15 minutes to make your presentation. You can use any or all of that time, and if there's time left over, then we'll have questions from the caucus to your presentation, and any comments that they may have.

With that, the floor is yours for the next 15 minutes. Thank you.

Dr. Glenn Bartlett: Thank you very much. Thank you for the opportunity to present to this committee. First off, I feel a need to explain briefly the context from which I make my observations. These are mine alone, and should not be attributed to any one organization.

As is very apparent, this is not my first rodeo. I practised surgery for a considerable period of time before going over to what my colleagues would call the dark side. I have worked with district health councils and district offices of the Ministry of Health and Long-Term Care. As well, I have worked for six years in another province with a different, but not necessarily better, regionalization model. I am just completing a half-time position at the community health centre in Grand Bend as their ED and a half-time position as CEO of a small rural hospital in Exeter. As such, I work simultaneously with both the South West LHIN as well as the Erie St. Clair LHIN. I'm about to become the executive director of the Windsor Essex Community Health Centre.

Perhaps it is my surgical background, but I would like to dissect the title of "local health integration." The LHIN's mandate controls roughly one half of the total Ministry of Health's budget, but that control, as I see it, is tightly exercised centrally—i.e. this is a centralized, not a local, delivery model of care. Secondly, this is not a health system but rather an illness system. The concentration of effort and dollars is on large urban hospitals. It is difficult for organizations such as CHCs, which provide health promotion and illness prevention services, among other things, to gain economic traction. LHINs do not have the financial mandate to deal with health promotion. In my opinion, this is a short-sighted oversight which will affect future generations.

Thirdly, integration has focused on hospitals integrating with one another, so-called horizontal integration. However, collectively, as a population, as we move from cradle to grave, we don't necessarily go horizontally. We tend to go from public health to primary community care to community hospitals to tertiary care, and some of us to long-term care. Why, then, aren't we talking about vertical integration rather than horizontal? That, indeed, is the average life trajectory of our population who depend on us.

Finally, I think it is apparent that, at this point in time, there still is no system as such but rather there

continues to be multiple silos and fiefdoms, although fewer than there used to be.

However, in spite of all the above, it is my opinion that the LHIN model is far superior to any previous Ministry of Health model that this province has had. It does allow input into local issues.

The shortcomings of this LHIN model fall under two headings in my mind: first of all, issues arising from the act itself, and secondly, issues arising from the implementation of the act.

It is widely recognized that Ontario health care transformation is necessary to keep our public-funded health care system highly performing and sustainable. This cannot be achieved in isolation. This is a collective challenge requiring combined involvement and effort from the health services providers as well as, in our case, the Erie St. Clair LHIN and our health care partners.

By establishing the Erie St. Clair LHIN, the province has given us the support needed for local health transformation by communicating with us in several ways, such as local planning, coordination, integration and delivery of key publicly funded health services.

We support the Erie St. Clair LHIN's integrated health service plan number 3, and the strategic direction that we are working in is in collaboration with that initiative, as outlined by the LHIN.

As a passing comment, it is my opinion that the omission of ambulance services and public health from the mandate of the LHIN is not a good one. The fragmentation that currently exists does not serve the needs of our patients, clients or residents in a true systematic, cost-effective way. These essential services should, in my opinion, be above local politics.

The second issue is how the act is implemented. I have first-hand knowledge of concurrent comparison of our two LHINs in the western part of the province. I have found Erie St. Clair to be responsive and approachable when it comes to problem-solving. They do have a true appreciation of the impact of decisions on our patients. We sure do not get everything we ask for—far from it—but we do get a thoughtful hearing if our requests are rational and persuasive.

0910

Now a bit about Windsor Essex Community Health Centre: We're one of five CHCs in the Erie St. Clair network. The Windsor Essex Community Health Centre was established in December 2009 by the amalgamation of Sandwich Community Health Centre and the Teen Health Centre. It is now one of 73 community health centres located throughout the province.

The CHC model of care—for those who aren't familiar with it—focuses on primary care, illness prevention, health promotion, community capacity building and service integration. The model of care attributes include comprehensive, accessible, client- and community-focused, interprofessional, integrated, community-governed, and takes into a great deal of consideration the social determinants of health.

Our centre serves the vulnerable population of this city and the surrounding region. Vulnerable populations are

individuals who face barriers to accessing and navigating health care-related programs and services. The following are some examples of the current vulnerable population that we are serving: children and youth; seniors; individuals suffering from chronic diseases such as diabetes, hepatitis C, heart disease and stroke; immigrants and refugees; individuals who are homeless or at risk of homelessness; individuals with disabilities; and individuals who are geographically or culturally isolated. The Windsor Essex CHC services are targeted based on the unique needs of this community we serve.

Some ways in which Erie St. Clair supported the Windsor Essex CHC:

- community engagement related to integration activities and facilities planning by providing facilitation for such an engagement;

- an operational review of the organizational structure and internal workflows to ensure that we are making the best use of existing resources—governance, staff, facilities and funding—within the context of a fully integrated organization;

- recommendations were made and a 12-month follow-up report was achieved;

- a review of all programs and services to determine appropriateness within a defined mandate and sustainability;

- a review of back office integration opportunities which resulted in the integration of payroll services with the Brockville General Hospital;

- a review of external relations with key health service providers and non-health service providers to evaluate the impact on primary health care for our residents, and to align with the LHIN and the Ministry of Health's strategic priorities;

- a review of the corporate culture following integration and the degree to which a new culture and leadership had been successfully implemented was determined—there were a few words there but it's an enormous undertaking for a corporate culture of two organizations merging together;

- a comparison with other CHCs in Erie St. Clair as to resources and availability and distribution, and adjustment of same;

- a consultation with the Association of Ontario Health Centres, which is the overarching organization for CHCs in the province, to clarify actual and emerging practices and look at best practice trends.

We have two ongoing capital projects, supported by the LHIN: (1) the relocation of teen health services, and (2) the relocation of Sandwich community health, both of which are located in some centre facilities.

We have engaged in a collaboration with Leamington memorial hospital in providing satellite services to their area.

We are participating with the Essex South Shore Health Link. Health care providers in Leamington, Essex, Kingsville, Wheatley and elsewhere have come together to create a health link, which is a new model of care where all providers in a community—including family

care providers, specialists, hospitals, long-term care, home care and other community supports—are charged with coordinating care for the people who rely most heavily on their services. Through this approach, clients, caregivers, providers and stakeholders co-design a desired future state of local health care that removes waste, increases capacity for change and improves value for patients who live in our communities. The health link data committee identified people diagnosed with congestive heart failure—which is really a failing pump, if you will—as an initial patient cohort for review.

We participate in regular one-on-one meetings with the LHIN to identify challenges and opportunities so that we can continue to improve.

The LHIN has provided us with dollars to support a mobile falls clinic assessment—one-time funding, a trial basis for the rest of the LHINs. This is in partnership with the VON, the Chatham-Kent CHC, the Grand Bend CHC and the tri-county public health entities. In other words, we're not doing it alone; it's a collaboration.

The LHIN has provided an annualized base funding increase for a nurse practitioner at our Street Health program that serves the homeless and those at risk of becoming homeless.

We are involved in collaboration with the LHIN to support the Southwest Ontario Aboriginal Health Access Centre by providing new base funding for a nurse practitioner for fiscal 2013-14. This will address the significant health care gaps and poorer health care outcomes of the aboriginal community by increasing effective, culturally appropriate service delivery.

The LHIN has provided one-time funding for minor supplies for our disadvantaged populations.

Finally, the LHIN has stabilized our chronic disease management activities by providing long-term, secure funding for that staff.

In summary, while LHINs are not a perfect model, they certainly are far superior to anything else that I have worked with in this province. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes. It will be the official opposition. Ms. McKenna.

Mrs. Jane McKenna: Thank you so much, Dr. Bartlett, for your dedication and hard work and the recommendations that you've brought forward. We're getting a bit of a consensus now, in doing this for the last few days, with people saying quite similar things that are very thoughtful. I really liked your vertical integration that you mentioned there.

But I have a question for you. You mention here that we have your current vulnerable populations. I would gather that you measure your success by the success of the patient going through the system. So when you're dealing with children, seniors, chronic disease—the list is quite extensive here—how do you measure the outcomes of those patients to see where you could better service them?

Dr. Glenn Bartlett: I'll answer it another way. One of the things we're trying to achieve is to provide care for

people in the community so that they don't go to the emergency department and plug up the emergency department. We've done some analysis of that, and I think we can show by numbers that the efforts that we're making are effectively decreasing the number of patients accessing the emergency department inappropriately.

For example, COPD patients, if they're not treated in the community appropriately, have a track record of recurring—sometimes 12 to up to 28 times for one individual. It's the same problem, which could be adequately dealt with in a community fashion. So I think the things we're doing help them provide that.

For the homeless people, if we can give them food, if we can deal with hep C, if they've got that, and other entities that are troubling—diabetes—then we can keep them out of the acute care system and living a more fruitful life.

So we measure it indirectly rather than—I think our impact is felt in other parts of the system.

Mrs. Jane McKenna: Yes, because it's—

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time, so we thank you very much for coming in, and I'm sure we'll use your presentation as we formulate recommendations in the report.

Dr. Glenn Bartlett: Thank you very much.

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the Erie St. Clair Local Health Integration Network: Martin Girash, chair, and Gary Switzer, chief executive officer. Welcome, gentlemen, and thank you very much for taking the time to come in today and make a presentation to us. As with the previous one, there will be 15 minutes in total that you can use all of or any part of that you wish. In any part that's left over, we will have questions from caucus.

0920

Dr. Martin Girash: Thank you, Mr. Chairman and members of the Standing Committee on Social Policy. Good morning. My name is Martin Girash and I am a psychologist by profession and the new board chair of the Erie St. Clair LHIN. I want to thank you for the opportunity to speak to you today on the impact of the Local Health System Integration Act, as well as our local health integration network, and the impact that these have had on our health care delivery.

My entire career of over 40 years has been in health care, from early years in children's mental health, to acute care as a retired hospital CEO, to more recently as a consultant for a number of community health agencies. As a result, I have worked through an era when there were no local health integration networks and, more recently, during their formative years.

One of the most important themes within the legislation is the requirement for community engagement. The

importance of including the public and our stakeholders in health care decision-making is very, very critical.

Characteristics of our communities within the Erie St. Clair LHIN range from medium-sized cities such as Windsor to rural communities like Petrolia, and everything in between. How citizens could best access health care varies greatly from one community to another. It's more related to where they shop than where health care services may have been located. Each community should have a say in how the system is structured, and needs a voice to represent their unique access requirements. The local health integration networks provide that voice. Prior to the LHSIA and the LHIN organizations, there was very little opportunity to have that say.

At the Erie St. Clair LHIN we believe in interactive communication, accessibility and engagement, and see ourselves as forerunners across the province in these areas. We are the local connection to the community and stakeholders—a role we take very seriously.

For example, we post online all reports, our public scorecard, expenses, community reports and other important information. We provide direct phone or walk-in contact with our staff and CEO for issues management. We have a two-business-day response policy to all email and letters, and are proud to say that we normally exceed that. This service is widely used by the public, stakeholders and all MPPs.

We post online our entire board package within 24 hours of our board receiving it, and we webcast our open meetings, so that everyone has the opportunity to both observe and comment on our work. We offer an open mike session at the start of each board meeting where the public can speak to us about something important to them. Additionally, we rotate our board meetings' locations throughout our LHIN and have a public session where we hear from the residents on a health care topic that is important to their community.

Through all of our work, we rely on input and advice from health care professionals, patients and the community. This is often done through town hall sessions, forums, surveys and working groups, to name a few.

An excellent example of this type of collaboration is our work on orthopaedic surgery. We have at the table all the chiefs of orthopaedics throughout our LHIN—

Mr. Vic Dhillon: Sir, can you just back off of the mike?

Dr. Martin Girash: Yes. Too loud? Sorry. We have at the table—how's that? Is that better?

Mr. Mike Colle: You just don't have to be that close to it.

Dr. Martin Girash: Okay. How's that? Okay? Sorry.

We have at the table all the chiefs of orthopaedics throughout our LHIN, patient representatives, health care providers and primary care physicians, all working together to improve care and make the system more coordinated, so that people can get their surgery as soon as possible. Our CEO may say more about that in detail; we're pretty excited about that effort.

The other day, I was at an announcement for our Chatham-Kent health link. The health link project identifies natural communities within a LHIN jurisdiction so that we can build on the existing relationships and the naturally occurring traffic patterns to form a meaningful and efficient flow for citizens of the community through their health care journey. As I said earlier, where people shop is as important as where they go for their health care, because of convenience and access.

As each partner spoke at this announcement, I saw in action how health links provide a linking of the many partners in a given community. This enables the various health care providers to connect with each other to provide a seamless transfer from one agency to another, something our patients have requested for years. So often throughout my career, I have heard from patients that services were excellent once you received them, but accessing them was a nightmare. The LHINs and the health link initiatives are finally addressing this concern.

Provincially, the LHINs provide a voice for our citizens to be heard at Queen's Park as well. Now we have a local body that is there to hear from our citizens on their health care needs and to be their voice at Queen's Park. Whether you come from Grand Bend, Windsor or anywhere in between, someone is working for you at Queen's Park, something those of us in the deep south have not felt that we've always had.

In summary, working in health care for over 40 years, I can attest to the fact that prior to LHSIA and its LHINs, there was a sorrowful lack of systematic connection among services, and this was the primary complaint of our citizens. While we still have work to do to connect the dots, LHSIA and the LHINs, particularly with the additional responsibilities for more of the health care system, are the threads that tie our quilt of a health care system together.

Now I'd like to turn the mike over to Gary Switzer, our CEO, who will provide specific examples of our work.

Mr. Gary Switzer: Good morning. My name is Gary Switzer, and I am the chief executive officer of the Erie St. Clair LHIN.

The LHINs have been around since 2006, and I have been here since the very start, as I joined in 2005.

In the past nine years, I have seen how the LHINs have matured. We have come a long way and, like any new or established endeavour, we still have room to improve, and reviewing the legislation will assist in our evolution. This is why we are here today.

As these hearings have progressed across the province, common themes are developing regarding the legislation and the value of LHINs in their local communities. I'm sure you will agree that the LHSIA legislation exists to make people's quality of life better by ensuring they receive the care they need, when and where they need it.

While I could talk about the details of LHSIA, it's more important to capture the spirit of the legislation as it is realized through the lens of patients, and it's why today I will speak to you about how the LHIN made a difference by improving end-of-life care in Erie St. Clair.

Death is one of the most difficult topics to discuss. However, it became easier when the voice of the community came together with the LHIN and our system partners to openly discuss and acknowledge that we were not living up to the expectations of people in their final days and that we needed to do something about it.

What I will speak about is a real-life example of what can happen when you bring people and providers together to improve the delivery of health care in their communities. The example I want to share encapsulates the value of our legislation; supports the themes of improved access, system coordination and value for money; highlights the importance of being local; and most importantly, demonstrates how care is being improved for patients.

My intent is to speak for a few minutes, then turn the floor back to you for questions. I hope that works for you.

It's amazing, what we have learned over the years by listening to our communities. In 2006, we were hearing that too many people were dying in hospitals when they wanted to die at home. Surveys indicate that over 95% of Canadians wish to die in their own bed, in their own home. Almost all of us want a choice of where to spend our final days.

It became obvious to us that throughout our LHIN, there was no common approach to support people to die at home, and there was not equitable access to the wraparound care families and patients needed. With the help of our End-of-Life Care Network and community partners such as the CCAC and hospice, we took action. The goals were simple: Provide specialized palliative care and wraparound services for patients and families. It took a team effort and local investments to make this goal a reality.

0930

The in-home team now consists of palliative care physicians, nurses, social workers, spiritual care, personal support workers and volunteers. People who once had few options regarding their end-of-life plans now have greater knowledge and trust in the care that is available in their communities.

The results were immediate, and news of the palliative outreach team spread quickly. The team had very rewarding experiences as they engaged patients and families at this very special time in their lives. The percentage of people dying in the hospitals who were diagnosed palliative was on the decline. Now, when patients and families are in distress, they have an alternative to the emergency department.

We know that for dying patients and their families, the emergency department is not their location of choice. Yet in Ontario, 40% of the patients who are within the last two weeks of their life visit the emergency department. Over 85% of patients made at least one visit.

Our Erie St. Clair palliative team now averts over 2,430 emergency department visits each year. Additionally, primary care providers report an increased comfort level in caring for patients at end of life now that they

have specialized expertise to assist them, should they need that level of care. Our initial evaluative survey confirmed that primary care providers were more confident in assisting their patients knowing that they could work in partnership with this specialized team. This team won a provincial award from Cancer Care Ontario and the Ontario Association of CCACs.

We rapidly expanded our palliative outreach teams to all corners of our LHIN. I'm proud of the efforts of these teams, and so far they have been able to bring comfort to more than 1,150 patients per year. More than 80% of the patients we help are able to have their wish fulfilled by dying at home.

Although it's easy to talk about success and show the measurable results, the real benefit to us and the LHIN and to our system partners is the positive impact to the patients, their families and the care team. Not only did we receive letters from families thanking us, but we know that the professionals on the palliative outreach teams are very fulfilled in their work. They now see the system coordination and how it all centres on the patient and their family. This includes integrating these teams into our health link structure to ensure access for our most vulnerable patients.

The good news is, we didn't stop with just the palliative outreach teams. Our board also approved funding for two new hospices so that every community in our LHIN has access to this type of care.

I remember the day our board approved the funding. There were over 60 people crowded into a small boardroom. People of all ages were there to tell us how important a hospice is to a community and how much of a difference a hospice program can make. I don't think there was a dry eye left in the room after the presentation.

As a result of these local investments, people in Erie St. Clair now have more options and specialized care when faced with end-of-life decisions. We can now proudly say that the same considerate care that was given to them at birth is now also available to them in death.

My involvement at the local level allowed me to leverage my experience to work with the Ministry of Health to establish a province-wide cross-sector committee to look at end-of-life and hospice care. Over 80 providers and stakeholders have now come together to form a declaration of partnership with the goal to improve the end-of-life experience of the patient while working to improve our health care system for everyone in Ontario.

I've always referred to our role in improving health care as a race that never ends. So let's make this a race and pick up the pace of transformation by making necessary changes to the legislation and continue to devolve more authority to the LHINs. Our legislation has enabled us to accomplish many things. However, changes are required in order to make the health system more effective and to improve the care for the residents in Ontario.

In closing, because we are local and in touch with our communities, we were able to develop a LHIN-wide end-

of-life strategy. Our community spoke and we listened. End-of-life care is just one program that has allowed us to improve access to care, improve quality and ensure the work we do is focused on the needs and wishes of the patient. As a result, we're building capacity in our system, not only in Erie St. Clair, but across Ontario.

Thank you for the opportunity to speak today. I have additional information that we've left behind as well. Dr. Girash and I will be pleased to take any questions that you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have one minute left, so if you can have a half-a-minute question, we'll have a half-a-minute answer.

Mr. Percy Hatfield: I'll do the half-minute question. You talked about the orthopaedic example. Do you have a real-life example of how that coordination has worked for a patient in this area?

Mr. Gary Switzer: Do I have a real-life example? Yes. It was last year that we had a number of patients come to our office with a member of Rick Nicholls's staff, with the surgeons, to talk about the delays in surgery. We were able to educate the patients, and the surgeons as well, and provide the patients with the information that they can go anywhere in our LHIN or other LHINs for surgery. I happen to know for a fact that a gentleman I've talked to a number of times from Bell River actually went to Sarnia to have his surgery, because it enabled him to get to Florida faster.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Much appreciated.

Mr. Gary Switzer: You're welcome.

MS. AGNES SOULARD

The Chair (Mr. Ernie Hardeman): Our next presenter is Lambton Elderly Outreach: Agnes Soulard, chief executive officer. Good morning.

Ms. Agnes Soulard: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presence. As with previous delegations, you have 15 minutes of time. You can make your presentation. You can use any or all of that time in your presentation. If there's time left over at the end, we will have questions and comments from caucus.

Ms. Agnes Soulard: Very good. Thank you very much. Thank you for the opportunity to appear before this committee to provide my perspective of the Erie St. Clair LHIN and its effect on the health care of Sarnia-Lambton. I must attest that these opinions are mine and mine alone, and I can speak only on my experience in the community support sector.

My name is Agnes Soulard, and I am the CEO of Lambton Elderly Outreach. I have extensive experience—probably more years than I'd care to admit to—in the health care field as a staff registered nurse, a supervisor, a manager in a hospital setting and now, of course, community. You might say that I have experienced both sides of the coin.

Our agency is a not-for-profit agency that provides home and community support services to seniors and adults with disability in Sarnia-Lambton. We offer a host of services that include transportation, homemaking, home help, home maintenance, Meals on Wheels, diner's clubs, community fitness programs, respite, friendly visiting, grocery shopping, client intervention and assistance, the SAFE fitness program to rest and retirement homes and, finally, a 55 Alive driver refresher program. We are truly a one-stop shopping experience.

The organization has been in existence since 1970, so we have a long history of working with many ministries and various branches of the ministries. I began my tenure with this organization 11 years ago, so I worked with a regional representative and a regional office based in London. The communication at best was fragmented, and monies to continue to operate were always scarce for the home and community support sector. The model was truly a medical model. A centralized, regional model was truly not the answer.

A key priority of the health care system right now is the move in care from acute-care facilities to home and the community. The LHINs are best suited to do this, because they are closer to their communities and recognize their communities' needs. Our LHIN has demonstrated their responsiveness to provider questions and concerns, and has increased their engagement with the community. They are very transparent in their communications and have held town hall meetings to obtain information regarding health care needs, or to address concerns that the community may have. Their website provides information regarding meetings, and frequently they circulate newsletters regarding new programs or initiatives.

Overall, the Erie St. Clair LHIN, through this local administration process, has given organizations like ours the opportunity to be included at tables to which we were not invited in the past. This is very important for making local decisions, local planning, sharing visions of health care and best practices.

Our voice has been heard. For example, we were at the Aging at Home table and were able to obtain monies for local initiatives. We received monies to expand our Meals on Wheels program, our friendly visiting and our transportation program, all in an effort to assist clients to remain independent in their own homes. I might comment that our transportation alone in five years has tripled in terms of the number of rides provided.

Ontarians and Canadians may be living longer, but we are not becoming healthier. A recent House of Commons health committee showed that the number of years lived in good health peaked in 1996 and has been declining since. As we know, the majority of seniors have at least one chronic condition; as many as one in four has two or more. More startling, 5% of health care users rely on our health system and account for as much as two thirds of public expenditures. Therefore, we realize that with an aging population, chronic diseases are becoming more prevalent. Our LHIN has become responsive to this need

and has established chronic disease prevention and management teams, as well as health links, and community support has again been invited to participate.

0940

Smaller families are often scattered across the country, making caregiving more challenging. We all must be as innovative and as efficient as possible. In an effort to assist caregivers and families, we are caring for clients on a 24-hour-per-day, seven-days-a-week basis. Our LHIN has expanded the respite programs available to caregivers, to avoid the burnout that often accompanies this role. We often find that the caregiver will be admitted to hospital before the actual client who is experiencing the disease, just because of this burnout.

The LHIN is not perfect. However, we are prepared to and want to work within the current structure to make the system work. Dissolving of the LHINs will not immediately improve the health system and may distract from the more immediate issues impacting the delivery of home and community care. Any review of the local administration of health care cannot ignore other interconnected structural challenges required to meet the dual policy goals of developing and maintaining a healthy population within manageable public health budgets. A progressive, modern health care system keeps people healthy and connected in their homes and communities, and not sick and alone in institutions. I believe that home and community support works because it offers local, flexible solutions which the LHIN has supported.

We conduct a yearly client satisfaction survey, and we frequently receive comments such as, "Were it not for your service, I would not be able to live independently in my home." This is a true testament of how our services accomplish the goal of keeping people in the community and out of hospital and long-term-care facilities. Therefore, it is a more cost-effective means of health care delivery than institutional care.

We are very conscious of the government's health care objectives to effectively deliver high-quality health care services to help prevent people from getting sick or requiring more acute care. These are the objectives of the home and community sector. We strongly encourage government to continue with these strategic investments, such as investments to help reduce hospital admissions or readmissions.

Caring for seniors at home costs 67% less than care provided in long-term-care homes and 95% less than care provided in the hospital. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms—we've heard that in some of the presentations we've had previously—while also decreasing long-term-care home placements and long-stay hospitalizations, all at a lower cost to the health care system. An example of this, in our LHIN, is the establishment of a Home First team to address barriers to discharge for hospitalized clients. Remaining at home as we age is where we want to be.

There are ongoing concerns in our sector—this is the community support sector. One concern is the shortage of

home and community health care workers. One of the reasons for the difficulty in recruiting and retaining workers is the disparity in compensation and working conditions between the community health sector and the institutional sector. Our recruitment and retention challenge is magnified by the inability of agencies to offer wage increases for PSWs, either due to the absence of base funding increases or, as in our situation, due to the wage freeze that was initiated three years ago. I have been told that in some agencies, this may create labour difficulties, which threaten client care.

We must therefore ensure that to meet the current and future demand for home and community support services, there is sufficient funding and flexibility afforded to agencies to attract and retain qualified personal support workers.

I would therefore request that the government review their present policies regarding the wage freeze.

As I suggested earlier in my presentation, the LHINs are not perfect, but I believe that a hospital model or a CCAC model is not the answer. The hospital model at one time was most appropriate, but at the moment it is not, with the many challenges I have already identified. The CCACs are not the answer, and it was demonstrated that competition drives down quality and CCACs are a very expensive model of care.

Achieving the widely shared goal of providing the right care in the right place at the right time may sometimes require integrated service between two or more agencies to maximize the effective and efficient delivery of care. We must therefore pursue smart integration. More can be done to streamline functions between the LHINs and CCACs and make for a more efficient delivery of service for our sector.

I would therefore support the continuation of the LHIN as the local model to make decisions. I would however, suggest that the CCAC and LHIN integration be explored. Certainly, a great deal of administration costs could be saved.

I would also suggest that not all the LHINs across the province are equitable and that there be a greater effort made to ensure that best practices are shared and implemented across the LHINs.

In closing, I encourage you to think strategically. Investing in home and community support services now will save the government money and improve the health of residents living in Ontario. I could speak to many more examples of how the LHIN has supported and worked with our community support sector to ensure that the right care is provided to the right client at the right time, but time is prohibitive. I look forward to continuing to work with our LHIN to improve the face of health care in our community.

Thank you for your attention today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about three and a half minutes left. Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. It was very thorough, very comprehen-

sive, and I learned something I didn't know, that we have a Wyoming, Ontario.

Ms. Agnes Soulard: Actually, we're the centre of Sarnia-Lambton, Wyoming, for those who aren't aware of that.

Mrs. Donna H. Cansfield: Wonderful. One of the things that I particularly appreciated was that you identified how difficult it was to navigate the system. You identified that in the health links it's 5%. That's a huge amount of money that goes to 5% of the population and therefore it spreads the issue, and I particularly was interested—I would like to ask the question around the CCAC and the LHIN integration model and how it could be, in your eyes, accomplished.

Ms. Agnes Soulard: The CCAC at present is really a brokerage model that has very little hands-on care. I believe that by eliminating the competition—the competitive model—and by integrating the CCAC and the LHIN, the LHIN can provide the delivery care model that the CCAC is presently providing.

Mrs. Donna H. Cansfield: So in essence, they're both in the procurement business and you're really just taking out one middle person or one—

Ms. Agnes Soulard: That's correct.

Mrs. Donna H. Cansfield: Excellent. The other question that I had for you, in closing, is how—again, you spoke to that important process of integrating services turf in order to provide for the client. How do you see that happening here?

Ms. Agnes Soulard: I think we can all work better together. I think that many organizations have excellent programs and maybe we need to amalgamate those programs and ensure that we're offering the best to all the clients and that it's less fragmented.

Mrs. Donna H. Cansfield: And do you see that as a role of the LHIN, to take the lead?

Ms. Agnes Soulard: Yes.

Mrs. Donna H. Cansfield: And that has to be supported by government.

Ms. Agnes Soulard: It has to be supported by government and have the buy-in of the participants at the table.

Mrs. Donna H. Cansfield: You realize it's a very uncomfortable conversation?

Ms. Agnes Soulard: Yes, I realize that.

Mrs. Donna H. Cansfield: But a necessary one.

Ms. Agnes Soulard: Yes.

Mrs. Donna H. Cansfield: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Very well done.

BRENTWOOD RECOVERY HOME

WESTOVER TREATMENT CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Brentwood Recovery Home and the Westover Treatment Centre: Mark Lennox, administrator of Brentwood Recovery Home, and Ron Elliott, executive

director of the Westover Treatment Centre. Thank you very much, gentlemen, for coming in this morning.

0950

As with the other delegations, you will have 15 minutes to make your presentation. You can use all or any of that time for the presentation. If there's any time left at the end of the presentation, we will have questions and comments from our committee. With that, the floor is yours, and the next 15 minutes are yours.

Mr. Mark Lennox: Thank you. With your indulgence, we will both present, and then all the questions at the end.

I do thank the Standing Committee on Social Policy for this opportunity to address the issue. I've been working in administration for a residential addictions agency since before the LHINs were first incorporated in 2005 and the subsequent passing of the Local Health System Integration Act in 2006. I say this as I would like to be clear that I experienced that transition.

The failure or success of the Local Health System Integration Act will not be measured by us, but rather by our consumers. Quick, consistent and responsive quality service across our geographic and demographic areas is paramount. We must all stay the course together in a unified effort to reach a truly people-centred treatment plan. But which plan? I believe that for real gains to be made in our sector we need to have long-term commitments from both the health care providers and the government of Ontario. The Drummond report recommends that Ontario "must set out a 20-year plan with a vision that all Ontarians can understand and accept as both necessary and desirable." I support this fully as I see no benefit in having a system that is bombarded with threats of being dissolved. To my mind, this is counter-productive to the effectiveness of the health care system as a whole and emotional blackmail for those we serve. Changes in messaging and direction do nothing to advance our work.

The LHINs have their champions and their detractors. Although the transition period may have been painful, I truly believe that we've rounded the corner. I can only speak for the Erie St. Clair LHIN, but over the past two years I've seen a dramatic upswing in communication and co-operation with the health care providers. Coupled with the new programs introduced over the past year, we have the potential to provide great benefits through easier access to appropriate care for our consumers. At this time, I'll speak only to the programs and committees that I'm directly involved with as a committee member or as a community partner.

The first would be Fast Access to Community Experts. In the youth system review published by the Centre for Addiction and Mental Health, all stakeholders identified insufficient access to service as a significant concern and area for improvement. The FACE program couples agencies willing to provide and set aside consistently available time slots to serve new clients and make those times available for referrals from other agencies. A facilitator has just been hired to assist those agency staff

to book the appointments for their clients, which will reduce wait times for access to many services.

The mental health and addiction network: The original committee was disbanded several years ago, which was unfortunate. A lot of time and effort had been put into that by both the HSPs and the LHINs. At the time it was quite upsetting. Today, I see it as an example of growing pains during that transition period. The network has since been revitalized with Dawn Maziak from the LHIN, and the network is comprised of representatives from key partner organizations to provide high-level strategic counsel to the Erie St. Clair LHIN to advance system-wide planning. So far, it has created the Erie St. Clair LHIN's mental health strategic plan and is now moving toward the creation of the addiction strategic plan.

I must note that this two-pronged approach is seen as unorthodox by many, but it is a local solution in response to both the unique and common priorities of local mental health and addiction treatment agencies and our stakeholders. In order to ensure that planning remains consistent, committee members are expected to commit to a minimum of two years.

The Windsor-Essex community capacity committee was formed to work with the Windsor hospitals to support the stage 1A submission for the new acute care hospital, but it included community agencies at the table. The purpose of the committee is to ensure health care services are delivered in the right place by the right provider. To date, approximately 50 initiatives have been identified as services that may move from acute to community care if it would improve the consumer experience.

The Erie St. Clair balance-of-care project: a collaborative effort to bring together the best available data and best available people, using input from both front-line providers and senior leaders, to consider the needs of our aging population. This co-operative project of the Erie St. Clair LHIN and the University of Toronto shows great promise for our community to access alternative levels of care.

Education: The Erie St. Clair LHIN's first governance webinar was January 14, with a presentation on strategic relationships. Our board of directors and I found it most instructive and are looking forward to future seminars.

The inner-city initiative: a short-term community transitional stability centre for persons with mental health and addiction issues. The program will accept males and females, over 16 years of age, not requiring hospital admission but in immediate need of service coordination. The target population will be frequent users of emergency departments, ambulance and police services. The goal is to stabilize the lives of these people through a more holistic treatment plan and supports, which will lead to less dependence on those emergency services.

Of course, the Ontario Telemedicine Network: The proliferation of this valuable tool by the LHIN promises to assist interagency and interdisciplinary services for communication. In our case, it allows consumers to have access to psychiatric services without even having to

leave the property. This cuts down on wait times, travel times and transportation.

The mental health and addiction nurses: New this school year, these nurses are embedded in our local secondary schools and have already become a huge asset. Their ability to facilitate communication between the school board, parents, local agencies and the young person seeking help with addictions has made a dramatic difference in the time it can take for some of these young people to access treatment.

The Brentwood care path: A serious gap in service was discovered, relating to the withdrawal management of chemically dependent youth under the age of 16. In a very short time, Dawn Maziak, from the LHIN, put together a working group, representing a broad spectrum of agencies and disciplines, to work toward establishing a safe pathway to treatment. This project is ongoing, and my best information is that we are very close to announcing a solution.

The Salvation Army Men's Addiction Support and Treatment Program: This outpatient program had suffered year to year with inconsistent funding from different sources and was in danger of being closed due to lack of funding. Last year, the Erie St. Clair LHIN committed to provide permanent funding. The eight-week program has an eight-person capacity, and 71 consumers have used the program in only the first three quarters of this fiscal year.

As we move forward, I cannot stress enough that we need the ability to plan our care paths well into the future while remaining nimble and responsive. Some believe that the LHIN system may not be perfect, but I agree with the Drummond report that they are our best option. As one who experienced the last transition, I can tell you that if you feel it's time for change, the benefits of modification will far outweigh the burden and time and expense of a "slash and burn and rebuild from scratch" approach.

In summary, I remain cautiously optimistic. If you had asked me my opinion six or seven years ago, my response may not have been as positive. As I said in my opening, I believe that we have rounded the corner. I submit that it is the Ontario government, with the assistance of all stakeholders, that is best suited to plan the health care vision to guide the LHINs for the next 20 years.

On a local level, my feeling is that if the direction and level of commitment from the Erie St. Clair LHIN continues or is allowed to continue, we may truly make a difference in the lives of those that we serve.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you.

Mr. Ron Elliott: Well, good morning—

Interruption.

The Chair (Mr. Ernie Hardeman): We'll just hold until—

Interruption.

The Chair (Mr. Ernie Hardeman): It would seem to me that the test works. We will carry on, and if the noise

starts again, we'll just stop and let them—and listen to that.

The floor is yours.

Mr. Ron Elliott: Thank you, Mr. Chairman. I appreciate that.

Good morning. Thank you for allowing us to present to you. As said by my colleague, I appreciate the opportunity to present to this committee as the executive director of Westover Treatment Centre.

I've been the executive director since April of last year. I've been a pharmacist for over 40 years in the health care system.

Interruption.

The Chair (Mr. Ernie Hardeman): We'll just hold it. We'll just recess until the sounds have stopped. We do have a cancellation following this presentation, so we have enough to time to get yours in.

Mr. Ron Elliott: Thank you, Mr. Chair.

The committee recessed from 1000 to 1005.

The Chair (Mr. Ernie Hardeman): Thank you. We are patient but not so understanding.

Thank you again. We'll call the meeting back to order, and we will reset your time so we can carry on from the time that was left. Thank you very much again for your patience and understanding.

Mr. Ron Elliott: Thank you, Mr. Chair. As said by my colleague Mark, I too appreciate the opportunity to present to the committee as the executive director of Westover Treatment. I've been the executive director since April of last year. I spent 40-plus years as a pharmacist in the community, and I served on the Westover board prior to that for many years.

The Erie St. Clair LHIN, like the rest of the LHIN structure, I believe, is finally hitting its stride. After years of becoming established and understanding their rightful role, I believe the LHIN structure is now on track to make a difference.

I can remember attending LHIN governance meetings as few as five years ago where the question from the LHIN was, literally, "What do you want us to do?" But today, with exceptional leadership, our LHIN is saying, "This is where we need to go. Here are some tools and resources. These are the expectations. How can we do it together, and how soon can we get there?" This is definitely not a time to be considering a wholesale change in structure.

Let me just touch on a few highlights. This LHIN at Erie St. Clair is visionary. A great deal of effort is expended in looking at future delivery models and how they can improve patient care as we're moving forward. There is an incentive to improve not only in financial ways but in client service delivery in the belief that the agencies and the professionals involved are engaged in that improvement objective. There is input from local providers, with open discussion and inclusiveness. Ways are being found to reduce duplication. There are incentives in place for innovation such as health links, a mental health and addiction network and the use of the Ontario Telemedicine Network. The development of an

integrated health service plan is focused on improving the patient experience.

Our LHIN has the same mantra, different words, that I often use at Westover: "What do we do? Why do we do it? What can we do better?"

Westover has received great support, resources and advice from the LHIN at every request, with positive suggestions and follow-up.

The LHINs need to have leaders who are savvy to political and community issues at play in the regions, using executive search best practices to ensure independence and that an appropriate combination of skills and expertise is brought to the table. That was a summary from the Drummond report.

The current LHIN structure underscores accountability. The Erie St. Clair LHIN is moving to an outcomes-based measurement that will cause all health service providers to look at their success in meeting their improvement targets.

The LHINs add value to the health care providers by encouraging integration of services, more rapid transfer of patient information, rapid access to specialties and consistency of service. Examples include health links, working towards an integrated care plan and a health passport for those high users of health care in Chatham-Kent, and the Fast Access to Community Experts, or FACE, program.

With another example—some may see it as simple—the Erie St. Clair LHIN supports the addiction assistance service at Westover, which offers a 24/7 emergency phone line and transportation to Windsor or London withdrawal management services and to treatment on an as-needed basis.

Addiction services are funded, but to a limited degree compared to the population with addictive disorders. Funding should be broadened with barrier-free access to a variety of service models, including abstinence, harm reduction and even home recovery. The creation of a strategic plan for addiction services within this LHIN has demonstrated their commitment to treatment options.

1010

It can be shown that individuals with addictive disorders are frequent users of the health care system. Responsible and well-delivered services will encourage recovery and reduce the demands for hospital and home care. Follow-up and aftercare programs, coupled with relapse prevention initiatives, are being supported by the Erie St. Clair LHIN.

Addiction treatment services play a vital role in helping individuals find a healthy lifestyle. Working in tandem with all health service providers and sharing of services such as aftercare continues that recovery process with easier access and reduced costs. Providing links to supportive housing, self-help groups, women's shelters and the like extends the continuum-of-care concept to these individuals—all of which are encouraged and enabled by the LHIN structure. Taking another line from the Drummond report, "A regional health authority should be clearly identified as the key point for integra-

ting services and institutions across the full continuum of care for a geographic area.”

Health links and the timely and co-operative interaction of all health service providers localized in the LHIN will reduce significantly the need for so many government ministries to be involved. It will remove the silos; it will improve the response. The LHINs provide local integration, sensitivity to the area, collective wisdom within the agencies served, community need and demographics, and a much more nimble response to change.

The Erie St. Clair LHIN has established a number of working groups and committees across the region to develop common approaches to health care and, along with other organizations such as providers of addiction treatment, encourage all of the local agencies to work together, improve care and reduce duplication.

Local influence within a region is more effective, responsive and cost-saving, as opposed to a centralized bureaucracy far removed from the patient population. Supportive LHIN involvement has encouraged development of aftercare programs, co-dependency programs, relapse-prevention programs, initiatives for youth services and services for pre- and post-natal women within the population dealing with addictive disorders.

The Ontario Legislature would be well advised to continue with the LHIN structure and encourage inter-LHIN co-operation and communication, but more importantly, empower the LHINs to make the best decisions possible for the communities they serve. Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time and just a bit. So thank you very much for being here this morning. That makes up somewhat for the interruption that we had.

Mr. Ron Elliott: Thank you, sir.

The Chair (Mr. Ernie Hardeman): For the committee, the 10 o'clock and the 10:15 one have both cancelled.

ERIE ST. CLAIR COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Next is the 10:30 one: Erie St. Clair Community Care Access Centre. Are they present?

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. Well, if they are here, then we'll just move on to that: Betty Kuchta, chief executive officer. Welcome. Thank you very much for being here. As with the previous delegations, you have 15 minutes to make your presentation, to use any way you wish. You can use any or all of it. Any time that's left over after your presentation will be questions from caucus. Thank you very much.

Ms. Betty Kuchta: Great. Thank you very much, Mr. Hardeman, Chair. Good morning, committee members. I'm Betty Kuchta, the CEO of the Erie St. Clair Community Care Access Centre, and I'm delighted to be

here to inform the committee and to advise the committee in this important matter of the Local Health System Integration Act review. I can say that in the gallery I have our board chair with us, Kathryn Biondi.

I wanted to tell you a little bit about myself. I've held the position of CEO of the Erie St. Clair Community Care Access Centre and its predecessor organizations—Chatham-Kent and Sarnia-Lambton—since 1997 and have enjoyed a long career in the public sector. I served in municipal government for the first half of my career, as the deputy clerk of the county from 1986 to 1996, working with the CAO and more than a handful of county wardens over the years.

I'm no stranger to being accountable to citizens for the delivery of value for money in a public sector environment, where your constituents are your neighbours and friends, and where collaboration was embedded into the design of the structure.

Upper-tier government, as the county was at the time, is a collaboration with member municipalities. Municipal governments—no matter what form they take, from single tier to regional—are a collaborative enterprise with a wide range of providers and citizens. I have carried this philosophy of listening to the constituent and translating their needs and wants into action through collaboration into my work as a leader of the CCAC.

I wanted to tell you a little bit about the Erie St. Clair Community Care Access Centre. We serve a constituency of 650,000 people, covering the area of Windsor and Essex county, Chatham-Kent, Sarnia and Lambton county. We provide health care services to nearly 37,000 individuals annually, allowing them to remain safely at home or assisting them with transition to facility care. We manage 900 calls a day coming in with respect to service requests and information about health care in our area.

During my presentation today, I will be addressing the following key points: the patient perspective on CCAC care coordination and services, the value of our work with patients to community capacity planning in our area and outcomes achieved through collaboration in governance leadership. Finally, I will offer my perspective on the work of the Erie St. Clair LHIN, in particular the value of a regional model of health care, and I would also like to make some comments on the question about the merger of CCACs and LHINs, since that was raised earlier.

Care coordination is at the heart of what we do at the CCAC. Patients value this aspect of our work, and tell us so. Our volunteer board of directors of 12 invites patients and caregivers to address the board to tell us their stories about their health care experience. We learn from these very personal accounts, and have implemented service improvements to address concerns expressed. A repeated theme in these accounts is the deeply held respect and appreciation for the advice and expertise provided by the CCAC professional staff who coordinate care for these patients. Using a combination of vignettes and quotes, I will briefly relay what we have heard.

One patient describes his experience as follows: “This care coordinator saved my home life, my family life ... at a time when I didn’t even think I could go home and resume normal living. She negotiated an effective care plan for and with me ... working with my physician, specialists and others, helping them to translate their treatment into my home environment. She even arranged for a social worker for my wife. I am at home doing the things I want to do and can do for and with my family.”

A family caregiver describes his experience thusly: “CCAC’s community resources and supports were essential in keeping my parents in their home; it was the quality and dignity of care that made the difference.” This family caregiver went on to acknowledge our care coordinators for their exceptional quality of service, noting he was very pleased with the flexibility in scheduling, the services provided and the knowledge and support from the care coordinators.

Here is another patient’s story: We became involved with this patient through a referral from the hospitalist to our behavioural supports care coordinator, who has special training and expertise in the transition of individuals with difficult conditions back into the community. With the CCAC’s involvement, the patient’s family noticed improvements in behavior. The family caregiver presenting to the board members referred to her mother’s care coordinator as “her guardian angel,” noting that the care coordinator’s approach was holistic and involved the family by asking their opinions on what would be best for their mother. As these adjustments were incorporated into the care plan, the patient’s aggressive behaviours declined. The patient has since moved into a community residence. Her mental state has greatly improved, and she continues to thrive in her environment.

Another patient reported that his care coordinator, through the innovative hospital-to-home resettlement program funded by the LHIN, was able to remove the barriers that would have prevented him from remaining at home. These are stories that we hear time and time again. They’re oft-repeated.

Here is how our care coordinators describe their work:

“My personal philosophy is that knowledge provides confidence even in the most vulnerable patients and families, and provides them with the tools to better cope when making the transition to home from hospital.”

“The individuals with whom I work value the fact that ‘I’m in their corner’ during a difficult time.”

“I think our biggest contribution is the time we can spend with our patients. So many patients over the years have said ‘this is the longest time that anyone has listened to me ... ever.’”

1020

Care coordination is our core service. Our care coordinators work with our patients, their families and other health care providers to identify each person’s individual needs, develop care plans and ensure that people get the right care to meet their needs.

As a result of this unique professional role in the health system, we are privileged to work with all health

service providers in our area: nurses, personal support workers, therapists, physicians, specialists, community health centres, family health teams, community support service agencies, rest and retirement homes, and long-term-care facilities. As well, we work with our civic and municipal partners in social housing, emergency services and public health.

Our reach is broad. This vast knowledge of community, health and social care resources, and the application of these to patient care, places us in an ideal position to make significant contributions to health system improvement, and we are doing so in a number of initiatives. The one I choose to talk about today is community capacity planning.

Major health care services in Windsor are undergoing a hospital capital planning process. A complementary and necessary process to this undertaking is community capacity planning. This initiative, directed, supported and funded by the Erie St. Clair LHIN, is being led by a steering committee co-chaired by our Erie St. Clair CCAC and the Alzheimer Society of Windsor-Essex County. The steering committee is comprised of community health and social care providers and hospital partners, so development of the plan is being managed by those on the ground delivering patient care, those with the expertise to fashion new models of community care that will work for patients.

This is an example of our Erie St. Clair Local Health Integration Network making good use of CCAC expertise and the collaborative partnership model to deliver on its mandate of health system improvements, driving towards better health outcomes for our area residents.

We expect the same exercise to occur in Chatham-Kent and Sarnia-Lambton, where other capital projects are under development, and we expect our LHIN to similarly use our CCAC expertise and the collaborative partnership model to develop the plans.

I want to move on to talk about governance leadership.

Our volunteer board members contribute their time and a great deal of energy to serve the residents of our area. The diversity of our area is represented on our board. It’s the board’s objective to be engaged in regional health care solutions, working through the voice of the patient. This is clearly stated as one of our board’s values.

These volunteers serve in order to do the right thing. When it comes to community-based health care delivery, governance leadership extends beyond accountability and oversight. It is about representation, and the belief that our patient and their caregivers will be heard.

Regional demographics contribute to particular care needs. For example, compared to the province, the Erie St. Clair population has higher rates of occurrence for a number of conditions, such as arthritis, asthma, diabetes etc. These needs warrant local action undertaken by those who know the region and our residents best.

Our board has a great deal to contribute to the conversation about health care priorities and health care improvements. Our board is working hard and has had success at establishing board-to-board relationships

within Erie St. Clair. This has led to new developments in service delivery. Examples are agreements with our First Nations communities for a shared-service delivery model; an agreement with the John McGivney Children's Centre for a new financial model to support sustainability and improve service to children; and the Sarnia-Lambton integrated care centre, a joint capital and services delivery initiative of the Canadian Mental Health Association Lambton Kent, the North Lambton Community Health Centre and the Erie St. Clair CCAC. These have all been supported and encouraged by the LHIN.

Our recommendations are twofold, and I'll make a comment about the third with respect to the question that was asked earlier.

A regional model of health care planning is important to our patients. The current model in place is working well in Erie St. Clair. We observe that the successful result of such a model is realized by pursuing strong consultation and partnership development, as well as ensuring that all health care organizations and medical practitioners are driving to provide care that is less complicated, delivers more value for money and, above all, improves the health of those we serve.

As you've heard, the Erie St. Clair CCAC has well-established relationships with a vast array of health service providers throughout our Erie St. Clair area, through our front-line work, through organizational leadership, outreach and partnership, and through the strength of our board trustees.

A strong community care system in Erie St. Clair is dependent on a strong care delivery network, one that sets out a clear path from the point where a patient will enter the system and addresses individualized care needs throughout their experience. This creates a level of expertise which is valued by all partners.

A large community web of services and supports exists in Erie St. Clair. The CCAC has used its technical capacity and human capital to access these resources for the direct benefit of our patients and caregivers. As noted, we have also struck our own partnerships and leveraged our expertise in creating new opportunities for care in the community.

As well, our LHIN has been using our expertise to positive effect. There are many examples of this: the implementation of resettlement and restorative beds, convalescent care beds and better housing options in Sarnia for young people with chronic conditions transitioning into adulthood in Sarnia.

A regional model allows for local care designed with the voice of our local residents in mind, with the ability to choose to use our area investments differently based on local needs. This has been occurring in our area, and this will continue to occur with the leadership of organizations such as ourselves and the LHIN.

We wish to highlight section 24 of the Local Health System Integration Act. This provision outlines that each LHIN and health service provider will identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient

services. Our LHIN has initiated governance leadership forums to address this requirement. We wholeheartedly support these forums while suggesting the development of measures to assess how well the LHIN is utilizing the leadership and expertise of existing entities to deliver on its integration agenda.

As local areas make the shift to community-based care and innovative care delivery models, the Erie St. Clair CCAC and others have a lot to offer. We encourage the LHIN to continue to leverage the expertise and the services of the CCAC.

I will now address the question about the merger of the CCAC and the LHINs, since the question was raised in a presentation. I don't think that major overhauls are what is required at this time. I think our system is working well. What we really have to focus on most is the separation of functions, and I think people sometimes forget that. We deliver care to patients. The LHIN plans and funds and demands accountability; it doesn't deliver patient care. This is a unique model for Ontario, which allows the LHIN to be in a neutral position to actually demand that accountability. If they were in the business of delivering direct care, there might be a tendency for them to favour that particular entity and to also miss out on the opportunity of the board governance leadership that's available from that particular group of volunteers, who have devoted service to the entity of delivering care to those in the home, in the community. I think you really have to think about that.

The neutrality that the LHIN offers to our area through two distinct functions of planning and funding—and of course, accountability—is really important to the landscape of health care in Ontario. Every single other entity delivers care to patients. The LHIN can demand accountability from each of us in a very neutral and objective way. So I don't believe it's the right thing to do at this time.

The Chair (Mr. Ernie Hardeman): That does conclude the time. Thank you very much for making your presentation, and I'm sure it will be of assistance to the committee as we move forward in this review.

Ms. Betty Kuchta: Thank you.

HOSPICE OF WINDSOR AND ESSEX COUNTY INC.

The Chair (Mr. Ernie Hardeman): The next deputation is the Hospice of Windsor and Essex County Inc.: Carol Derbyshire, executive director. I understand that we're slightly ahead of schedule, but she's here, so we look forward to hearing from her.

Thank you very much for your insightfulness to realize coming in a little early was going to pay off today.

Ms. Carol Derbyshire: That's exactly why I did it.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here. As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If

there's time left over at the end, we will have questions and comments from the members of the committee. With that, the next 15 minutes are yours.

Ms. Carol Derbyshire: I thank all of the committee for the opportunity to present to you today. My name is Carol Derbyshire. I am the executive director of the Hospice of Windsor and Essex County.

1030

I'd like to begin by providing you with a bit of information regarding the Hospice of Windsor and Essex County. For many, the hospice symbolizes hope, providing care designed to enhance quality of life for patients and families in our community. It is the first community-based palliative hospice village in North America. Founded in 1979, we are currently celebrating 35 years of providing services in Windsor-Essex county.

The hospice village serves all patients and their families dealing with a life-altering diagnosis. In simple terms, this means that hospice services are available to patients and their families from pre-diagnosis to bereavement. Services are holistic in nature and can include wellness programs, support groups, fitness programs, counselling, education, pain and symptom management, and, of course, palliative care.

Hospice currently has one eight-bed residential home in Windsor and has been approved for a second home to be located in Leamington. It is expected that this second home will be operational later in 2014. The hospice is proud to offer all services at no cost to patients and families and provided in a space that is both serene and welcoming, responding to the diverse needs of a multi-cultural community. However, because the operations of a residential home and hospice services are not fully funded, substantial volunteer hours are required along with fundraising initiatives.

The success of our program is a result of our dedicated staff of approximately 55 that consists of palliative care physicians, nurse-educators, social workers, alternative health care providers, administrative staff and a virtual army of over 600 dedicated patient care volunteers. We offer a comprehensive program that addresses the physical, social, emotional and spiritual needs of our patients and families available on a one-to-one basis or a family basis.

We receive approximately 35% of our funding from the ministry. The Erie St. Clair LHIN has recognized the need for services in our community and has provided funding support to us. The remainder of the funding for our many programs comes from a group of dedicated volunteers through such initiatives as fundraising, donations and grant-writing initiatives. We enjoy wonderful support from our community. They have embraced palliative care right from the very beginning.

As I speak to you today about the role of the local health integration networks and more specifically the Erie St. Clair LHIN, I want to acknowledge the important role the LHIN plays in identifying the unique needs in each of the communities throughout the Erie St. Clair region. The ability of the LHIN to work with the com-

munity health care providers to identify local needs and then be able to allocate funding based on these needs ensures the more timely provision of services to patients and family members. With local representation, the LHIN is able to advocate for funding for community-based services that ensures patients and family members have access to and receive services in the most appropriate location. Their local presence means that there is active community engagement that not only involves health care providers but also includes the residents within Erie St. Clair.

As I begin, I'd like to acknowledge that this review process provides a key opportunity for community health care agencies to continue to advocate for the role of the LHIN and to ensure that health planning remains integrated within the region by:

- enhancing the capacity and mandate of the LHIN as it relates to planning across the complete continuum of care that not only considers illness but that also includes prevention, education and self-management, and the dying and grieving process;

- providing for greater accountability for the LHIN to promote processes for community engagement;

- continuing to build a system of viable community-based health services; and

- being responsive to community needs.

The LHIN's existence is critical and essential in ensuring the funding of community agencies that provide programming to meet the regional needs of the area. The objects contained within the local health integration act indicate that the LHIN is responsible to plan, fund and integrate the local health system. The Essex county LHIN has been successful in working collaboratively with its funded agencies to achieve this goal.

Our LHIN has also worked within the context of the broader health system to ensure the voice of both health care providers, and patients and their family members are supported in the context of care planning. This is clearly seen in the palliative care system that is being developed here in Windsor and Essex county. The LHIN has recognized that palliative and advanced care planning is essential, not only for cancer patients but for persons with chronic disease as well. They have heard from the community that people want to remain in their homes, and in order to enable that to occur, education is essential. We have seen funding enhancements to support this education both for care providers and for patients and families who support their loved ones. We are expecting patients and families to keep their loved ones at home, and these people don't have formal training, so they need a lot of support and education.

In addition, the LHIN has acknowledged the need for residential palliative care beds in the community and Hospice's role in providing continuity and managing these beds within Essex county. As we plan and develop a new 10-bed hospice residential home in Leamington, we are working collaboratively with both the LHIN and Leamington District Memorial Hospital to ensure that the service needs of the south Essex community are met. We all recognize that the demographics of this community

are different than those within the city of Windsor, and collectively we remain committed to meeting their needs as well.

The Erie St. Clair LHIN recognizes the important role they play in planning for a truly integrated health system that is broader than their mandated role. They are currently participating in meetings initiated by the Leamington District Memorial Hospital to plan, in a broader health context, to meet the health and social needs of patients, clients and their families within the south Essex area. This initiative involves community agencies that receive funding from a variety of governments—provincial, federal, municipal—that are all committed to providing services more efficiently to address the broader determinants of health. The outcome is to achieve greater collaboration in health and social services that effectively address the well-being of everyone.

Leamington hospital is developing a campus; many of the Windsor agencies are setting up satellites on their site; St. Clair College will be setting up out there, offering teaching education to health care providers—a one-stop shopping approach.

The LHIN has also supported the community in its deliberations to develop a single acute care hospital site. They participated in processes to realign the Windsor hospitals, with the result being one acute care hospital, governed by Windsor Regional Hospital, and a second health care organization, Hôtel-Dieu Grace Healthcare, governing all non-acute care services as well as specialized community-based services.

This realignment has been supported by the LHIN, and was achieved in a timely manner because of the local representation and the dedication of the boards of directors for each of the hospitals and the LHIN as well as their management teams.

As all health care providers seek to improve community engagement activities, enhanced supports are required to involve the active engagement of our residents. At Hospice, we make this a priority and an objective as part of our planning process, to ensure services provided are based on consumer needs.

We recognize that as health care evolves in the future, the community needs to be involved in building design and layout, including parking. They also need to provide input on administrative functions, such as registration; the functionality of the programs; and quality indicators, including those elements that are important to the patient or family member.

Patients and family members often have important insights into the care they receive that provide for better experiences and improved outcomes. We believe that the LHIN can actively facilitate this type of engagement and support health care agencies in ensuring the active role of our residents in providing input, as the success of the service and the LHIN goals is not only based on costs and outcomes, but on how the patients and families perceive the services and the care they receive.

1040

In building a viable, effective and efficient integrated system of health services, there is a need to develop an

aligned system that spans the various components funded by the LHIN. While we typically plan for the transition between the acute care and the non-acute systems, or the hospital and community sector, we should expand how we view the need for services. We need to think in terms of there being one health system that serves the population and the patient, and supports the family and/or non-professional care provider. The LHIN has facilitated this mindset and acknowledges the need for staff roles that span acute care hospitals and community-based services. An example of this that I can speak to is the palliative care liaison nurse. She is a hospice nurse who works within the hospitals and within the community to effectively plan for the movement of patients between the hospitals, to either the hospice residential home or their own home. By funding this position, the Erie St. Clair LHIN has supported this mindset. It is more of these types of positions that would benefit a patient's care, whether for acute care, chronic disease or end-of-life/palliative care, and the LHIN recognizes this.

As a community agency, we recognize the need to ensure that the funding we receive from the LHIN produces results that align with the integrated health service plan they develop and, equally important, meets the needs of patients and families. We recognize the need for due diligence and stewardship for the funding we receive, and work in collaboration with the LHIN to ensure results. The local presence of the LHIN ensures recognition of needs based on communities within the LHIN. This is important in ensuring that the funding they provide produces results based on quality outcomes for patient care.

As the LHIN and health-funded agencies plan for their future, it's important that the LHIN support and facilitate the continued development of a system plan for services that the community needs, and not necessarily for service gaps identified by many of us, the provider agencies. We can assess and plan for services to be divested from the hospital, or even to the hospital, but changes must be made in the best interest of the person receiving care.

These services and programs that result from planning exercises should be planned, funded and executed equitably, regardless of the location or organization responsible for the management of the service. In the future, as the need for community-based services grows, it is important that the agencies can attract the required human resources and infrastructure to support this growth, have the systems that support best practices and achieve a greater level of stability in order to assure accountability and accurate reporting. The local presence of the LHIN allows for collaboration in this level of planning as they recognize the needs and challenges of community-based agencies.

During the past seven years during which the LHINs have existed, our hospice has had a very positive relationship and great support from the board of directors, the CEO and the staff. They have recognized that hospice care and its programs are a priority, because they address the needs of the person served. They are advocates for

local communities within Windsor and Essex county, Chatham-Kent and Sarnia-Lambton, and understand our needs. We look forward to their continued support as all health care partners—whether they be funded by the LHIN or a different payer—plan for services that meet provincial priorities and, more importantly, meet the needs of our patients, clients and family members.

As someone who has worked in the health care field for—I'm in my 35th year this year, and I've lived through many things, and was very active when the district health council was here. I sat on many committees. We did some excellent planning and reports would be sent off, but very little came of them. There was a lot of frustration in those days. Once the LHINs came and were set up—we're seeing things happen, so I encourage you to support them.

Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you coming in and being here early.

COMMUNITY LIVING ESSEX COUNTY

The Chair (Mr. Ernie Hardeman): Eleven o'clock: Community Living Essex County. Are they present? Oh, very good. Nancy Wallace-Gero, executive director, thank you very much for coming in, and we very much appreciate you being here. You will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end, we will share it with the committee for questions. With that, the next 15 minutes are yours. Thank you.

Ms. Nancy Wallace-Gero: Thank you very much and, really, thank you so much for the opportunity for Community Living Essex County to speak to you today. We're not a typical health care provider, but I'm going to relate to you a number of issues that I think are very important ones if we're going to really have a coordinated health care system that includes the needs of people with an intellectual disability.

First of all, I'm Nancy Wallace-Gero, and I'm the executive director of Community Living Essex County. We are a service-providing agency, primarily funded by the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

We have a history of over 50 years in our community and, of course, are part of a network of Community Living organizations across Ontario, across Canada and, indeed, across the world.

Our fundamental belief is in the inclusion of all people within their community, so that they utilize the supports and services that are available within their community and have equal access and equal opportunity to all forms of care, including health care.

One of the reasons that we felt it was very important to come here today is—my message is about improving communication between developmental services and the LHINs and the Ministry of Health. We need to be included in planning and processes if supports are going

to be improved for people with an intellectual disability. The voice of people with an intellectual disability, their families, and agencies serving people with an intellectual disability need to be included.

I have a package of information that will be distributed, or has been, to you. I'm not going to read my report. Rather, I'm going to highlight, because it's too long and I will run out of time.

I want to talk to you, first of all, about a couple of successful collaborations. As I said, inclusion is very important to families and individuals who have an intellectual disability. They're not asking for separate programs, but they are asking that the needs of people with an intellectual disability be considered and addressed in community, in a similar way to all people.

We have some really good examples of some great collaborations that are going on, but I don't know that the Ministry of Health or the LHINs are even aware of them. For example, in-hospital dental procedures: There's a local dental surgeon, Dr. Paul Smith, who has opened the door to dental surgery within the hospitals. Many of the people supported by agencies like the one that I represent are people that cannot have some of their dental procedures, or maybe even all of them, conducted in a traditional dental office, so they need to be in a hospital setting. Dr. Smith has fought tirelessly with all kinds of people to ensure that those opportunities are available. That door should be opened. It's a need; it has got to be addressed within the community.

Another great partnership has been with the Alzheimer Society, both provincially and locally. We had some really good collaboration and a community conversation about community-based homes for people with very challenging needs, including dementia. We, in Community Living, as you may know, support many, many people with all kinds of needs, and I'll speak a little bit more about that in a moment.

1050

A bit about our operations: Our annual budget at Community Living Essex County is just under \$30 million. All of that is not provided by the province. We do fundraise and we do have a number of contributors. We serve over 600 people of all ages and their families, and increasingly, we're supporting people with very, very challenging needs, especially in this time of huge need within our community. We've been forced to, of course, offer our supports and services mainly to people who have the most significant needs and just can't live in community without our supports. We're a grassroots organization. We're formed by families, and so we remain responsive to community stakeholder needs.

Some 8% of our total expenditure is administration. This is very typical in the DS sector because of the way we've grown and emerged. I don't know that that's true in most other organizations in other sectors or even within the community services sector.

We operate 55 affordable, accessible residential homes in typical neighbourhoods throughout our community, both rural and urban. On average, three or four

people live together in a home. We offer 24/7 support in these homes. We utilize direct support professionals who have a developmental service worker degree, a two-year college program. It's a community residential model that works for affordability and quality of life.

Some of the challenges that we face: We are indeed different from the health care sector. People with an intellectual disability have a lifelong condition that doesn't change. You can do a lot of things that can improve and offer opportunities, but their condition is what it is. The support needs are therefore lifelong.

We use a person-centred planning model. We moved away from institutions in 2009. The government closed all provincial institutions for people with intellectual disabilities, which was a wonderful move, the right thing to do, and since that time we are very focused on building a strong community support system.

It seems to us that health care and the LHINs are still somewhat focused on an institutional model, and that's of concern. We support people with very complex needs. I mentioned that earlier. People in our homes have insulin injections, oxygen therapy, tube feeding, suctioning, colostomy care, tracheotomy care; people with severe osteoporosis, dementia, palliative care, end-of-life care. We utilize community services to train our staff to support us when something is beyond our knowledge, and that works. It's much more affordable, and it truly does provide a quality of care that is quite unique and I think something that needs to be considered in our community health care.

When changes are made in the delivery of community health care without our input and knowledge, gaps in service and access to service problems can result. So we really feel strongly we need to be a partner in decision-making around health care in our community.

Long-term care: There are 12,000 people on waiting lists in Ontario. Unfortunately, there is a crisis spilling over into the Ministry of Health, especially in long-term care. Inappropriate placement of young people within long-term-care facilities—people who have an intellectual disability—is happening, at great expense to the people of Ontario. This is inappropriate and can be prevented. It's so unfortunate that we're allowing this to happen because we're not sitting down and talking about it and making sure that we come up with better solutions for everyone.

So two solutions—a few things we'd like to suggest; I have five quick recommendations. One is that the LHINs and Community Living need to have improved communication and collaboration at all levels. There needs to be collaboration between the Ministry of Health and the LHINs with MCSS, the Ministry of Community and Social Services, and MCYS to fund preventive services for families to avoid the inappropriate crisis admissions to both acute care hospitals and long-term care.

The LHINs need to explore the mental health system to ensure appropriate care for all people with mental illness, including those who have an intellectual disability, and to further facilitate collaborative relationships

for mental health providers in the DS sector. The LHINs need to also look at facilitating enhanced awareness of the DS sector in the health care community.

Just a quick sideline: We have developed from our organization very strong collaborative relationships with several faculties at the University of Windsor. Particularly, I'd like to mention the nursing faculty, as well as the department of kinesiology. We're doing extensive work on educating students who are within those faculties, so that they go out into the world understanding the needs of people with an intellectual disability. This needs to be more than just an off-chance one-off because we've developed the relationship. This should be a coordinated system of understanding that's going on around the province.

Finally, we recommend that the LHINs and the Ministry of Health and Long-Term Care reference a document that was developed in November 2013 through CAMH: Dr. Yona Lunsky's work, which is called the Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario. This is a very good document that covers a lot of the health care concerns and issues, and I've put an executive summary in your package.

Just quickly, thank you for your time. I hope that my comments and recommendations are not seen as criticisms—that's not how they are intended—but rather are taken as positive opportunities to do better in health care for people with an intellectual disability and their families. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your great presentation. If you'd went five seconds shorter, we'd have to leave it with one, but we have time for about a minute and a quarter from each caucus, starting with Mr. Nicholls.

Mr. Rick Nicholls: Thank you very much, Mr. Chair. Nancy, thank you for your presentation and the passion that you bring to your role. Also, it's good to see you again. Thank you for the tour that you gave me of two of your resident homes in Leamington a little while ago. You educated me in that as well, so thank you for that.

Also, I appreciate the concerns and some of the solutions. A lot of times, people just give us problems without solutions. The solutions that you've brought forward will certainly be examined by this committee and reviewed, and hopefully we can come up with something again.

Again, nor did I take your comments of the LHINs as criticism. I've had first-hand knowledge, working with our Erie St. Clair LHIN back in Chatham, with the executive director, Gary, and his staff, and I know the work that they are doing in many different areas, so again, thank you very much.

I don't really have a question. I just had some comments for you.

Ms. Nancy Wallace-Gero: Thank you.

The Chair (Mr. Ernie Hardeman): Good thing, because you haven't got time.

Mr. Percy Hatfield: Thank you, Mr. Chair. Nancy, good to see you again.

Ms. Nancy Wallace-Gero: Hi. Thank you.

Mr. Percy Hatfield: You mentioned off the top that you and your group should be included in the planning. I'm just wondering: Does that mean you're not included now, but you want to be in the future as we go ahead?

Ms. Nancy Wallace-Gero: Yes. We often hear about reports when they're issued to the public. We really don't get called to tables within health at all for discussion or for representation of the needs of people with an intellectual disability, so when we read reports, we're often reacting, which is not the right way to go around the fact that people's needs are being left out.

Mr. Percy Hatfield: So is that a shortcoming with how the local LHINs coordinate their activities with you?

Ms. Nancy Wallace-Gero: I don't know. I think that they just tend to look at health partners more than they do beyond. I think my recommendation is just that they take a broader look, include other people beyond health care partners and look at social services, especially a sector like ours that is so involved in health care in the way that we deliver services.

Mr. Percy Hatfield: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for your presentation. For those of us who've been on this committee all week, we're hearing a lot from support organizations such as yourselves that deal with different ministries, and we have heard of some successes in terms of the South West LHIN, in terms of bringing the type of agency that you represent in a little bit more.

1100

And so, I guess one of the things we're learning is that it's really important for all the LHINs to get together and examine best practices. As you know, LHINs were essentially formed to try to break down the silos within health, and that has been quite a struggle and is coming along nicely, I would say, at this point. I think the next incremental piece is clearly to bring agencies such as yours in.

I don't have a question, but thank you, again, for bringing this to us, in our face. The impact on health is absolutely there, in terms of the work that you do.

Ms. Nancy Wallace-Gero: Thank you for that encouraging comment. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming to make the presentation—

Ms. Nancy Wallace-Gero: You're very welcome.

The Chair (Mr. Ernie Hardeman): —and to express those concerns.

Ms. Nancy Wallace-Gero: Thank you. Yes. Good luck with your work.

The Chair (Mr. Ernie Hardeman): Thank you.

Mr. Mike Colle: Thank you for your work.

ENTITÉ DE PLANIFICATION DES SERVICES DE SANTÉ EN FRANÇAIS ÉRIÉ ST. CLAIR/SUD-OUEST

The Chair (Mr. Ernie Hardeman): The next one is the French organization to provide French services in the

Erie LHIN: Jacques Kenny. Thank you very much for coming here. I would remind the committee that number one on your translator—if you're looking for translation, the number one on your gizmo—is the French-English translation. Thank you very much.

You will notice from your introduction that I'm not too fluent in French, so I apologize for that. But we do thank you for coming in and making a presentation to us on this very important subject. So thank you, again.

For the next 15 minutes, the floor is yours. You can use all or any of that time. If you have time left over, we will then have comments and questions from the committee as it relates to your presentation. Thank you, again, and the next 15 minutes are yours.

M. Jacques Kenny: Chers membres du Comité permanent de la politique sociale, je me présente : je suis Jacques Kenny, directeur général de l'Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest. Je suis accompagné de mon président du conseil d'administration, M. Nil Parent, qui arrivera sous peu.

Un long chemin a dû être parcouru pour en arriver à la présence des entités de planification des services de santé en français dans le paysage du monde de la santé. La présence francophone en Ontario remonte à plus de 400 ans, mais ce n'est qu'en 1984 que la Loi sur les tribunaux judiciaires confère au français le statut de langue officielle dans les tribunaux. Ce n'est qu'en 1986 que la Loi sur les services en français garantit au public le droit de recevoir des services gouvernementaux en français dans les 25 régions désignées bilingues. Et ce n'est qu'en 2006 que la Loi sur l'intégration du système de santé local prévoit la création d'un conseil consultatif provincial sur les services en français. Elle indique comment les francophones seront impliqués dans l'organisation du système de santé tant au niveau provincial qu'au niveau régional.

En octobre 2008, le ministère de la Santé et des Soins de longue durée émet un premier projet de règlement sur l'engagement de la collectivité francophone en santé qui propose des comités consultatifs.

En mai 2009, le commissaire aux services en français de l'Ontario publie un rapport spécial sur les services de santé en français recommandant de modifier le projet de règlement de 2008 et de prévoir de réelles entités de planification des services de santé en français pour chacun des RLISS.

Et en janvier 2010, la ministre de la Santé et des Soins de longue durée, l'honorable Deb Matthews, annonce un nouveau règlement sur l'engagement de la collectivité francophone en application de l'article 16 de la Loi de 2006 sur l'intégration du système de santé local, proposant la désignation de six entités de planification des services de santé en français en province.

Suite à tout ce cheminement est né en mai 2011 l'Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest, communément appelé l'entité 1. L'entité 1 appuie et conseille deux RLISS, soit Érié St. Clair et celui du Sud-Ouest. Son territoire comprend les

comtés suivants : Grey, Bruce, Huron, Perth, Oxford, Middlesex, Lambton, Elgin, Norfolk, Chatham-Kent et Essex. Le territoire desservi compte près de 30 000 personnes qui ont le français comme première langue officielle parlée.

Le RLISS d'Érie St. Clair compte environ 18 000 personnes ayant le français comme première langue officielle parlée alors que le RLISS du Sud-Ouest en compte 11 000. Dans l'ensemble du territoire, 24 % de la population francophone est âgée de 65 ans et plus. Il reste encore plusieurs milliers de francophones dit bilingues ou allophones qui ne sont pas inclus dans ces statistiques.

Le rôle de l'entité de planification est d'épauler et de conseiller les deux RLISS sur différentes questions, à savoir :

- les méthodes d'engagement de la collectivité francophone dans la région;

- les besoins et priorités de la collectivité francophone de la région en matière de santé, y compris les besoins et priorités de différents groupes au sein de cette collectivité;

- les services de santé mis à la disposition de la collectivité francophone de la région;

- l'identification et la désignation des fournisseurs de services de santé relativement à la prestation des services de santé en français dans la région;

- les stratégies visant à améliorer l'accès, l'accessibilité et l'intégration des services de santé en français au sein du réseau de santé local; et finalement

- la planification et l'intégration des services de santé dans la région.

Suite à ce cheminement, j'aimerais vous donner un bref aperçu des accomplissements, des collaborations et des changements effectués depuis l'arrivée de l'entité Érie St. Clair/Sud-Ouest.

Notre entente d'imputabilité parle de comité de liaison mais ne stipule pas sa composition. Nous avons, avec l'expérience vécue, élaboré un processus de rencontres que nous considérons comme meilleure pratique. Suite à l'élaboration du rapport conseil par l'entité, les agents de planification et les coordonnatrices se rencontrent pour préparer un plan conjoint qui est suivi d'un plan d'action plus spécifique à chaque RLISS.

Pendant l'année, des rencontres régulières ont lieu à tous les niveaux par les partenaires pour tenir compte du progrès dans la réalisation du plan d'action conjoint. Des ajustements sont faits au besoin. En plus de cela, les directeurs généraux de l'entité et des RLISS se rencontrent au besoin également. Les RLISS invitent l'entité à venir présenter annuellement au conseil d'administration les réalisations de la dernière année et les projets pour la prochaine. Voilà la structure mise en place pour assurer une meilleure communication de part et d'autre.

En 2012, l'entité a entrepris une étude intitulée Santé des francophones et utilisation des services de santé dans les Réseaux locaux d'intégration des services de santé d'Érie St. Clair et du Sud-Ouest. Vous en avez une copie dans vos pochettes. Près de 1 200 personnes ont pris le

temps de répondre à ce questionnaire quand même assez exhaustif. Nous avons élaboré ce questionnaire avec les coordonnatrices des services en français des deux RLISS ainsi qu'avec d'autres professionnels des RLISS et des épidémiologistes du bureau de santé publique. Le taux de réponses a dépassé de loin nos attentes et celles des RLISS, et nos francophones ne se sont pas gênés pour faire des commentaires sur les services de santé en français.

Suite à ce sondage et les commentaires de plusieurs aînés, nous avons entrepris une deuxième étude, celle-ci avec deux objectifs spécifiques : le premier, tenir une étude de marché et de faisabilité pour la construction d'un établissement multifonctionnel d'hébergement et de santé, ou autres options, et le deuxième objectif, étudier les besoins spécifiques en matière de services de santé des personnes âgées francophones. Nous venons de recevoir le rapport préliminaire et le partagerons en temps et lieu avec la communauté. Nous savons cependant, d'après les commentaires de nos aînés, que s'ils doivent se retrouver dans un foyer ou une maison de soins de longue durée, ils aimeraient recevoir leurs services en français et être entourés de gens qui parlent français, afin de pouvoir socialiser dans leur langue maternelle qu'ils ont maintenue tout au long de leur vie.

Comment avons-nous procédé pour entreprendre cette étude? Encore, nous sommes allés chercher la collaboration de nos RLISS. Nous avons travaillé un appel de proposition qui conviendrait aux besoins et préoccupations et des RLISS et de l'entité. Suite à l'embauche du consultant, les agents de planification ont travaillé de pair avec les coordonnatrices pour organiser des groupes de discussion et des rencontres avec des intervenants et des informateurs clés de la communauté et des RLISS. Ce partage d'efforts et d'informations fera en sorte que le document final soit mieux étoffé que si notre travail avait été fait en vase clos.

Un autre projet de collaboration est celui d'une trousse d'outils sur les services en français. Cette trousse est une initiative conjointe des coordonnatrices des services en français des deux RLISS. Elle est destinée aux fournisseurs de services de santé, en particulier ceux qui sont identifiés et désignés pour offrir des services en français.

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La trousse est un recueil de renseignements et de ressources utiles pour soutenir la planification et la prestation des services en français. Elle met l'accent sur le principe de l'offre active et sur les façons pour les fournisseurs d'y parvenir. La trousse a été partagée avec les coordonnateurs des services en français de tous les RLISS et présentée aux directeurs généraux des autres entités de la province, ainsi qu'auprès de plusieurs partenaires et intervenants. Elle sera aussi présentée aux 17 directeurs généraux des réseaux de santé au Canada. Le commissaire aux services en français de la province, M. François Boileau, était présent lors du lancement officiel à Chatham récemment. L'entité est heureuse d'avoir joué un rôle de consultation dans cette initiative

menée par les coordonnatrices des services en français des deux RLISS.

Il y a d'autres façons dont nous avons travaillé ensemble avec nos RLISS lors des trente derniers mois de notre existence. Je vais en signaler trois ou quatre :

Nous avons travaillé avec deux groupes et nos RLISS à l'identification et la désignation de deux fournisseurs de services, Services à la famille Windsor-Essex et le Centre d'aide et de lutte contre les agressions à caractère sexuel du comté d'Essex. Ces deux organismes sont dans le RLISS d'Érie St. Clair. Nous avons été invité par le RLISS à participer à l'élaboration et la préparation de la désignation et l'identification de ces deux organismes.

Nous avons eu aussi une discussion initiale en octobre 2012 avec un exploitant de maisons de soins de longue durée concernant l'identification d'une aile francophone dans nouvelle maison dans le RLISS d'Érie St. Clair qui est en construction et qui ouvrira ses portes cette année. C'est le RLISS qui avait coordonné cette rencontre, et nous attendons le suivi de cette rencontre.

Il y a deux autres projets qui ont été mis en place par les RLISS. Premièrement, il y a le programme de télépsychiatrie qui a été financé par le RLISS du Sud-Ouest. Nous sommes au tout début de ce projet. Nous espérons que l'organisme qui va piloter ce projet va pouvoir offrir des services en français aux francophones de la région. Il y a aussi une autre initiative, celle-ci qui a été financée par le RLISS d'Érie St. Clair. Le RLISS d'Érie St. Clair a financé un projet où une infirmière praticienne est située à Pain Court, une communauté francophone de la région, et cette personne-là offre des soins primaires aux aînés de la région.

À la lumière de toutes ces belles choses que je viens de vous partager, est-ce que nous avons vécu des frustrations? Absolument. Est-ce qu'il y aurait place pour amélioration? Définitivement. Est-ce que l'entité est prête à contribuer pour faire avancer le dossier des services en français? Sans aucune hésitation.

Parfois, on se pose des questions, à savoir si les services en français seraient meilleurs et plus efficaces si le fonctionnement du système et/ou ses exigences étaient différents. Par exemple, les RLISS développent un plan de services de santé intégrés de trois ans qui est approuvé par la suite par le ministère de la Santé. Est-ce qu'il serait possible de faire le même exercice mais au niveau des services de santé en français?

Est-ce qu'on devrait demander aux RLISS de préparer un rapport annuel sur l'amélioration et l'augmentation des services en français offerts sur leur territoire? À qui diriger ce rapport? Le ministère de la Santé? Au commissaire des services en français de la province? Quelles seraient les solutions apportées s'il n'y a aucune amélioration appréciable des services en français?

Comment peut-on assurer l'intégration de la perspective francophone dès le début et tout au long du développement des politiques, programmes et initiatives entrepris par les RLISS ou ses fournisseurs de santé? Pourquoi ne pas être proactif et exiger un plan de service en français pour toute nouvelle demande de financement

ou de renouvellement avant l'approbation par le conseil d'administration du RLISS?

Comment procéder à l'identification des francophones de façon systémique afin de pouvoir mieux planifier les services en français au niveau provincial?

Mesdames et messieurs, je ne possède pas les solutions à toutes ces questions, mais je sais pertinemment que certaines de ces stratégies pourraient nous aider à avancer le dossier des services en français dans la province. Ce ne sont là que quelques réflexions de notre part.

Vous recevrez d'ailleurs un mémoire beaucoup plus détaillé et d'envergure lorsque le regroupement des entités vous rencontrera à Ottawa et vous présentera son document.

Que de chemin parcouru, mais il en reste encore beaucoup à faire, et la coopération de tous et toutes est requise pour arriver à bon port. Mesdames et messieurs, merci de votre écoute et votre attention.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a quarter, and it goes to the third party.

Mr. Percy Hatfield: Jacques, thank you for coming in. It was very hard with this. The translation devices weren't working very good. It was all full of static. I think I caught a lot of it, but right towards the end, it got too bad. I had to take it out of my ear.

Your recommendations at the end: You were saying you wanted more attention paid to the issues of health care for francophones?

Mr. Jacques Kenny: I've known you for so many years; we took courses at the university together.

When we did our study on health care and use of health care services by francophones—as I said, you have a copy in English also of that document—it was fairly universal. A lot of francophones indicated that they would like to have health care services in French, but they don't know where to get them and they're not sure if they would get them anyway. I can give you examples. Recently, an individual called me and said, "I asked for services in French when I went to emergency at a hospital. They asked me if I wanted my services in French. I said, 'Yes,' so after triage they put me in a room, and I waited an hour and a half. No one came to see me. I came out and they said, 'Where are you going?' I said, 'Well, no one has come to see me.' They said, 'Well, you asked for services in French.'" And she said, "Well, if I ask for them in English, would I get them faster?" And within a few minutes she was served.

It was nice to say, "Would you like services in French?" but then after that, it went through the same ritual that a lot of francophones go through when they ask for services in French. Yes, they're available, but once you actually ask for them, what we call active offer, they're no longer there; they disappear.

It's only one example. There are a number of other issues. I spoke briefly to seniors, and our consultant who is working on another document has indicated that, according to statistics, we have probably about 200 francophones in homes; however, none of them are regrouped

into one area. We have asked a provider if we can have a wing in one of the buildings that is being built. That would be a pod of 32 beds. We have yet to receive an answer, and that was in October 2012 that we asked for that.

The Chair (Mr. Ernie Hardeman): I'm going to have to stop you there. We've exceeded the time. We thank you very much for your presentation. I just wanted to point out how bad my French is. As I was looking at the name, I saw "south west." I didn't realize that referred to the South West LHIN until you mentioned the places in my riding in your presentation. I'm not only listening to the LHIN story, but I'm learning French today.

Mr. Jacques Kenny: Exactly. As I said, we work with two LHINs.

The Chair (Mr. Ernie Hardeman): Thank you very much.

M. Jacques Kenny: Merci beaucoup.

VON WINDSOR

The Chair (Mr. Ernie Hardeman): Okay. Our next presenter is the VON Windsor, Jon Jewell. Is Jon Jewell present?

Thank you very much for being here. We welcome you and we thank you for taking your time to come. You have 15 minutes to make your presentation. You can use all or any of that in your presentation. Any time left, if it's less than four minutes, will go to one caucus, and if it's more than four minutes, we split the time evenly between the three caucuses. With that, the floor is yours and the next 15 minutes are yours.

Mr. Jon Jewell: Okay. Thank you. I'd just like to say a big thank you, first off, for the opportunity to be able to come and present to the committee today and to represent the views of the VON in Erie St. Clair. Just to put a little bit in context, I'm going to talk a little bit about VON Canada as an organization, and then I'm going to talk about some of the issues that are affecting our life and reality within this LHIN area.

The VON Canada is Canada's largest not-for-profit home and community care organization. It has been around for well over 100 years, created back in 1897. We're a registered charity and it's a substantially large organization. We currently have, nationwide, around 14,000 staff and volunteers, and locally within the Erie St. Clair LHIN, that translates into about 350 paid staff and literally an army of well over 800 volunteers who deliver many of the essential services that we deliver on a daily basis. Across Canada, we are present in 52 sites, 1,200 communities, and we have a portfolio of over 75—I think it's exactly 75, actually—different programs and services.

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We are a part of the Ontario Community Support Association. That is a network of agencies, as you're probably aware, that service over a million Ontarians on a regular basis with a whole variety of services.

VON branches respond to the unique and changing health care needs of communities across Canada. We like to think that one of the things that we're able to do is to be able to respond very rapidly to gaps in service. We provide programs and services that no other home care provider offers: volunteer visiting, meal programs etc.

We touch the lives of sick, lonely and isolated people who other providers cannot and often will not serve. So it really is reaching out to people who are extremely disadvantaged in their home communities and providing services as close to home as possible.

VON's approach has resulted in programs that are cutting edge. They are things that are innovative. We've opened some of the first nurse practitioner clinics in Ontario. We provide services to, often, communities through our clinics. We've developed respite care services—and particularly in this LHIN area, in Erie St. Clair, some very innovative respite programs. Our ability to adapt and transform is what has given us longevity.

Just to list some of the things that we do: We provide caregiver supports and programs, personal home and support services, a whole range of community support and volunteer services, and crisis services. We're active in health promotion and education. We provide occupational health services. We're active in the provision and design of mental health services. We offer a range of palliative care services. We have seniors' exercise and wellness programs and senior respite programs. We are active in prenatal education and parenting classes. We have children's programs, including the Kids' Circle children's bereavement program. We're the lead agency for the Ontario Student Nutrition Program in southwest Ontario, so we're actually the flow-through agency for the funding for breakfast and snacks for kids. We have a chronic pain management program to help people who live with daily pain conditions. So there's a whole range of activities from prenatal right through to end of life. That's a little bit about VON.

What I wanted to talk a little bit about in addition to setting that as a context was a little bit about this area and some of the challenges that present in this area. This is the southernmost LHIN and, as you're probably aware, it comprises Essex county and the municipalities of Chatham-Kent and Lambton, including the city of Sarnia. Our footprint matches exactly the LHIN footprint, so our basket of services matches exactly the geographical boundaries of this LHIN.

This LHIN has a growing seniors population, which is not uncommon across Ontario, but it's actually more pronounced here in that our population in this LHIN is aging faster than Ontario as a whole. At the same time, our younger population is dropping, so where we've got an increase in numbers of seniors aged 65-plus, it has actually increased from 14% in 2006 to 16% at the most recent count. We actually have a reducing younger population as well, which impacts on issues like volunteer recruitment and the provision of volunteer services.

The residents of Erie St. Clair think they're healthier than they actually are, as well. We've got a very high

level of chronic disease, we've got a higher-than-average mortality rate and we have a lot of people who endure years of ill health. If you measure that in terms of life-lost rates, we actually have a population of people who bear co-morbidities and chronic disease for extended periods of time.

We have some pretty poor health practices across Erie St. Clair, as well. Nutrition, smoking, alcohol consumption and obesity are all disproportionately high in this area and present a challenge.

Chronic disease places a burden on the health care system, and it reduces quality of life for those who bear those chronic diseases. Forty-one percent, at the most recent count, of Erie St. Clair residents have a chronic condition, and 17% have multiple chronic conditions. This increases dramatically with age, and if you look at Erie St. Clair residents who are 65-plus, more than half have two or more chronic conditions that they live with.

The reality is that this puts a huge burden on acute hospital care, but when those people are not in hospital and not receiving acute care—and oftentimes that's not the most appropriate place—then there is a challenge about providing the extent of services in the community to be able to meet the needs of those individuals.

Within VON, we remain very supportive of the principles that were laid out by the government when establishing the LHINs through legislation. It's all about local planning and accountability, community integration and co-operation, and respect for the Canada Health Act.

The LHIN has worked to create a strategic framework for organizations like the VON to operate within, and they have a very comprehensive integrated health service plan which sets the pathway forward and creates a lot of the detail for focus. We are extremely supportive of the direction of that plan.

The LHINs are focused on community service provision. There's a realization that acute care is the most expensive type of provision, and there is a utilization of acute care that is inappropriate and very draining on budgets. I know that the LHIN are working very diligently to consult with the community about finding solutions that allow services to be delivered in community locations as close to the home as possible, which, in reality, is what most patients would prefer as well.

We don't see that dissolution of the LHINs would improve the health system in any way. Actually, it's the view of the VON that that would be very disruptive to some of the work that is ongoing at the moment, so we're very supportive of working within the framework that is currently existing. It's our experience that the LHIN has been extremely responsive to questions and concerns and has sought the interaction of organizations like the VON.

If I could quote a couple of examples here of ways that we are very actively working with our LHIN in consultation and in design of programs: We've been brought together as part of the integrated health service plan priority of tackling chronic disease, and there's a huge consultation exercise at the moment which is designing pathways for our patients that are dealing with issues such as CHF, COPD, diabetes and stroke.

Those pathways are looking at how people can be triaged away from acute care and into community locations with the support of organizations like the CCAC, and how those programs can be delivered out into the community at much reduced cost, and with better returns for the individual. So, we've been very active in helping with the design of those pathways, and it's as a result of the LHIN reaching out in consultation.

The LHIN has been driving the move toward health links, and VON have been invited to be present at a lot of the tables for these health links as they start to become operational. For instance, within this LHIN boundary, the first health link was in Chatham-Kent. Our director sits on the leadership team. Myself, I sit on the leadership team of the health link out in Leamington-Essex-South Shore. The Sarnia health link, which is going to be following on behind very quickly—we have an invitation to participate in that consultation piece as well.

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That's about understanding the needs of individual communities and the specific needs that they need, and then helping to design how that basket of services works for the needs of that specific population.

The VON is very active, again with the LHIN's leadership, in the design of mental health services as well. We've been brought to that table to see if we can assist. There's a lot of activity at the moment around an inner-city site for mental health and addictions in Windsor, and the VON is delighted to say that we are a very active participant in designing those services. We will be providing the nutritional component for that site and also some of the nursing when that site comes on stream. We're very excited about the difference that that will make. We see the LHIN's bold leadership as being very integral to redesigning the way that that particularly disadvantaged group receives service.

Obviously, there is more that can be done. There are huge challenges out there. There's an over-demand on acute services. There is a lack of trained workers within the health and home care system. It's becoming increasingly challenging to recruit volunteers to deliver services. Some of these challenges sort of interact to make a big problem and create huge challenges, as I say, but we're confident that, working together, we will find a route, a way out, and we will find the solution to these individual difficulties.

A progressive, modern health care system keeps people healthy and connected with their homes and communities, not sick and alone in institutions. We believe very strongly that home and community support works because it offers local and flexible solutions. Keeping people living independently in the community and out of hospital is a more cost-effective means of health delivery than institutional care. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms while also decreasing long-term-care home placements and long-stay hospitalizations, all at a lower cost to the health care system. We really feel that organizations under the Ontario Community Support Associa-

tion umbrella—and speaking on behalf of VON—have a huge part to play in delivering these types of programs.

Many OCSA members are struggling to serve a quickly growing population while solidifying the services that they already provide. The community supports sector funding needs to properly take into account a comprehensive picture of administrative costs.

Interjection.

Mr. Jon Jewell: Okay, thank you. I'm just coming to the end.

To be realistic, we've designed a lot of new services, and when we provide these services—as a not-for-profit charity, we try to provide these services at best value, but there is a reality that these things need coordination and they need integration and administration.

The last thing I would say is, our LHIN has recognized the need for volunteer programming, based on the local community needs assessment. The LHIN's targeted funding to this aim assists greatly in staving off costly service utilization. I'd just leave you with the thought that volunteers are a cheaper way of delivering service than paid personal support workers or nurses, and we are able to offer that as part of our sector.

I'd like to thank you once again for the opportunity to speak.

The Chair (Mr. Ernie Hardeman): Thank you very much for making your presentation. Your time has been consumed. We thank you very much for taking that time to share your thoughts with us.

Mr. Jon Jewell: Thank you.

LA CHAUMIERE RETIREMENT RESIDENCE

The Chair (Mr. Ernie Hardeman): The next one is La Chaumiere Retirement Residence: Carolyn Barko.

Ms. Carolyn Barko: Hello. Thank you for having me.

The Chair (Mr. Ernie Hardeman): Good morning. Thank you very much for being here and taking the time to come and talk to us. You have 15 minutes to make your presentation, and you can use any or all of that time to make that presentation. Any time left over we'll offer to the committee for questions and comments on your presentation. With that, thank you very much for being here. The next 15 minutes are all yours.

Ms. Carolyn Barko: Okay. Thank you. My name is Carolyn Barko, and I am a Chatham-Kent resident, currently working here in the Windsor-Essex area. I have worked in long-term care, in the seniors' care business, for about 20 years. I was the CEO of a community service organization in Chatham-Kent, and I was also the CEO of a retirement home. Currently, I'm working with a for-profit retirement organization here in Essex.

I'm here today to talk to you about some of the great things, in my opinion, that the LHIN has done since its inception as it relates to non-traditional partnerships.

The retirement home industry, as you know, is large. We have over 50,000 beds in Ontario, and the expecta-

tion is that it grows by about 20% in the next decade. Recently, we have become regulated by the Retirement Homes Regulatory Authority. Most providers supply some type of care.

In 2006 or 2007, while I was working on a few committees with the LHIN, it was quickly identified that retirement homes provide a lot of care, and it was really great to see that non-traditional providers were being recognized for the amount of care that they give to seniors and that the Erie St. Clair LHIN quickly identified that retirement homes were going to be a large part of the solution for our aging population.

Our rates in the retirement home industry range from about \$75 to \$95 a day, which is significantly less, of course, than a hospital stay, which ranges anywhere between \$500 and \$1,500 a day. Our representative organization, which is the Ontario retirement home association, is working hard to bridge these partnerships between government organizations and non-traditional partners.

As I said, while working with the LHIN many years ago, originally we had some struggles working with non-traditional partnerships, but I can only say that since that time in 2007, there have been enormous strides in terms of the LHIN supporting these non-traditional partnerships through organizations such as CCAC. Both organizations have been just great to work with—truly—in terms of helping people, like those in retirement homes, provide care and to bring down the cost of the system.

One particular example: Recently, the CCAC of Erie St. Clair, supported by the LHIN, a retirement home and a community service organization, established a program whereby the patients who were in ALC beds and/or presented in emerg were redirected to a retirement home. The retirement home took these clients 24/7. They were supported by the CCAC in terms of physio and extra supports. As well, after their 90-day stay, they were supported by a community service organization that provided Meals on Wheels as well as day-away programming. So, in effect, we immediately reduced the ALC beds, and we immediately reduced the cost from, say, \$500 a day to \$85 a day. Those people were, then, with the help of the discharge planners from CCAC, supported to go back home. This was a plan to go back home, but while they were convalescing, they were allowed to stay in a supportive environment. Then the CCAC made the transition to home and included community supports.

When I started working with the LHIN, we talked a lot about system integration. It has been a very difficult go for system integration, but this project is an example of how far we have come from an acute care to a non-traditional partner, working with the CCAC to help these people get back home and to stay home with supports. That is such a great example of system integration—one of the best I've ever seen. I can also say that this LHIN in particular—we're the first in the province to try this.

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Some of my recommendations going forward are that the Ministry of Health support the LHIN in these endeav-

ours; that they support these non-traditional partners; that they should open up some of the HSP to allow some of these non-traditional partners to be part of the HSP scenario; that there be more non-traditional partners explored. Retirement homes are one of many that can provide a really economical, efficient way to provide care in this province.

The other thing that this particular project does is that we figured that it actually saved the system about \$650,000. So this really needs to be recognized, and the Ministry of Health needs to support the LHIN in all of their endeavours as they go forward in these non-traditional partnerships.

I know that we're working on the dollars following the patients, and the LHIN has been very proactive in this area, but if we are actually going to support choice and accessibility to the Ontario residents, we need to work on this sooner and faster so that the dollars follow the residents. They don't just go to the HSP that provides the care. It needs to follow the residents so that you can get the most accessibility, you get choice and you get the most effective use of your dollars.

That is the example that I wanted to provide to you today, because it's really a glowing example of how the LHIN has progressed in terms of their system integration and their partnerships with non-traditional providers.

I just wanted to say, in closing, that the retirement home industry is really receptive to working with governmental organizations. I am very, very happy to be one of those non-traditional partners that has had the privilege to work with Erie St. Clair LHIN and all their leadership.

I thank you very much for having me today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about two minutes per party. We'll start with the government side: Ms. Cansfield.

Mrs. Donna H. Cansfield: Currently, there are some regulations around retirement homes. But if, in fact, you end up with an HSP, there has been some criticism that you're not on the same set of standards as long-term care. How do you feel about that?

Ms. Carolynn Barko: It's true that we aren't on the same set of standards. I hope that we never become that, because I've worked in long-term care, and the standards actually work against the client, in my opinion.

I think you have to trust in your own government and their own regulations, so that is really up to RHRA to decide on whether or not the retirement home in question is qualified enough to be an HSP.

Mrs. Donna H. Cansfield: But it's the government that set those standards for the long-term-care home that you just criticized, and you now want them to set the standards.

Ms. Carolynn Barko: I don't want them to be the same. I'd like them to be very similar to acute care. There are all kinds of standards in health care, and the ones in long-term care in particular are overbearing and—

Mrs. Donna H. Cansfield: So it's just a higher funding level.

Ms. Carolynn Barko: Yes.

Mrs. Donna H. Cansfield: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: I would like to thank you for coming, because it was really interesting. We were given some background, obviously, on Erie St. Clair. The number one priority of the LHIN was to improve outcomes and alternate level of care, ALC. You've given us a very practical example of how the LHIN addressed this as their top priority. They looked at the whole continuum of care in terms of the opportunities. Obviously, we know that retirement homes do form a very, very valuable part of that continuum. So I just wanted to thank you so much for giving us a great illustration.

Ms. Carolynn Barko: Thank you. Although I know I'm here to speak about the LHIN, it really is in conjunction with the CCAC, too. Those two organizations working so well together are really how this is happening. The LHIN is supporting the CCAC to have those partnerships, and I'm just urging the Ministry of Health to support both of those agencies.

The Chair (Mr. Ernie Hardeman): Mr. Nicholls.

Mr. Rick Nicholls: Carolynn, it's good to see you again. How are you?

Could you just give us a quick breakdown again? You talked about a savings of \$650,000. How did that come about? What was included in that? How did you come up with that number?

Ms. Carolynn Barko: A part of it was the amount of days that the client would have stayed in hospital in an ALC bed, running at about \$500 a day.

Mr. Rick Nicholls: At \$500 a day. Okay. Yes.

Ms. Carolynn Barko: Yes, in comparison to being in the retirement home at \$100 a day, in addition to the potential for them either to go to long-term care or to be integrated back into their homes. Those were all factors that were included in the cost.

Mr. Rick Nicholls: I see. Okay. Thank you very much.

The Chair (Mr. Ernie Hardeman): Anything further?

Mr. Rick Nicholls: No.

The Chair (Mr. Ernie Hardeman): Okay. Third party? Mr. Hatfield.

Mr. Percy Hatfield: Just curious: La Chaumiere—is that the one where the staff worked without pay for months and months last year?

Ms. Carolynn Barko: Yes. La Chaumiere is a retirement residence in Emeryville that went into receivership—it must've been last year. Since then, it's been purchased by a gentleman named Harmen Verbrugge, and it has had no labour issues since, I think, December 2012. It's actually an excellent organization. He's redoing everything.

We just recently took on the Brouillette Manor residence from Tecumseh, the long-term-care facility who had to evacuate. He was great. He stepped up to the plate in the community and took on 20 residents. Yes, it's a great organization—very happy to be a part of it.

Mr. Percy Hatfield: What does it say about the dedication of the people who work there, who continued providing a service without pay for months on end?

Ms. Carolynn Barko: Well, they were paid by the union, actually. They—

Mr. Percy Hatfield: The union paid them, but the employer didn't.

Ms. Carolynn Barko: And they did get all their back pay, but I can't tell you enough—they asked me to consult with them for a while, and the reason I stayed is because of the staff. Those staff are so committed to those residents and that organization, despite all the things they've been through. In 2012, they had some hardships, but they've had a lot of hardships over the years. They are actually amazing, amazing people who have made my job there a pleasure.

The Chair (Mr. Ernie Hardeman): Anything further? If not, I thank you very much for your time—

Interjection.

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Nothing to do with this witness.

The Chair (Mr. Ernie Hardeman): Thank you very much for your time, and we really appreciate you taking the time to come here and inform us on the—

Ms. Carolynn Barko: Thank you for having me.

The Chair (Mr. Ernie Hardeman): I think it's the first presentation directly related to the retirement homes, so we very much thank you for your input.

Ms. Carolynn Barko: You're welcome.

The Chair (Mr. Ernie Hardeman): Thank you very much. Yes, Ms. Jaczek?

Ms. Helena Jaczek: Just before we recess, Mr. Chair, I wanted to thank our researcher for getting us the figures on health care employment within the LHINs, but I would of course like a little further information, if I may, in relation to this. What I would like to see is also the staffing of the LHIN itself. We have the employment within the LHIN, but I do not see the LHIN's actual staffing of their own organization, so I was wondering if we could have that across all of the 14 LHINs.

In addition to that—and I think this would be very easy to do—what I'd like to see is a staff-to-population ratio in each of the boxes in the chart, because there are incredible disparities as we look at these numbers. In other words, as an example, just looking at the Central LHIN hospitals, we have some 10,230 staff; if we could put that in context in terms of the population of that particular LHIN, as a ratio, and in each of these boxes produce that number, as well as the staffing within the LHINs, I would be very appreciative of that.

The Chair (Mr. Ernie Hardeman): Okay. Anything further on that?

Mr. Mike Colle: I've asked for some further information about the number of people working in health care: the number of physicians, for instance, and the number of people employed by the CCACs through contract, the VON and all the other agencies that do the work of the CCACs, just to get an idea of how many people are involved in health care delivery in each LHIN area.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. Nothing else? Lunch is pre-arranged at the restaurant upstairs, so the committee recesses until we finish lunch.

The committee recessed from 1149 to 1300.

ASSISTED LIVING SOUTHWESTERN ONTARIO

The Chair (Mr. Ernie Hardeman): Welcome back. We'll call the committee back to order.

Our first deputation this afternoon is Assisted Living Southwestern Ontario: Leo Muzzatti, director of human resources and strategy management. Leo, if you want to take a chair at the table there. Thank you very much for being here. You'll have 15 minutes to make your presentation. You can use any or all of that time. If you don't use all that time, then we will open up it up to questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Leo Muzzatti: Thank you very much, Mr. Chair. I welcome you and members of the committee. Those of you who are not from Windsor, I welcome you to Windsor. Those of you who are from around here, I welcome you home.

As indicated, I'm a director of HR and strategy management at Assisted Living Southwestern Ontario. Our organization is a not-for-profit agency that provides quite a number of community services, but I think it's fair to suggest that the bulk of the services that we deliver are to provide attendant care assistance to individuals with physical disabilities and limitations, and assistance with tasks of daily living. Our mandate provides us with many opportunities to embrace and to directly participate in implementing the provincial initiative of promoting the very excellent concept of aging at home.

We've been doing this as an organization for quite a long time. We've existed as an organization since 1938, having gone through a number of name changes and various evolutions. We now find ourselves today being a very integral part of front-line delivery of home care while promoting independence in this community of Windsor and Essex county and, more recently, expanding beyond those boundaries.

I am very happy to be here today to convey to this committee, what with your role, that our LHIN has been instrumental in recognizing, adopting and promoting accessibility to care in the home and in the community, particularly when acute or institutional care is not needed or is not the best option. We do believe that the LHINs are the vehicle to continue this role.

However, we do harbour some continuing concerns. There can be no question of the increasing general recognition of the economic value of keeping people healthy and connected in their home and in the community. I apologize if aspects of what I am delivering to you today in my message are something that you've often heard, whether it be here today or in your travels in other communities, but, if that's the case, I ask you to bear with it

and allow it to be testament to the importance of the principle and the concept, if it is repeated.

People's needs, in most cases, can be met in their home or in the community while significantly decreasing the costs that are associated with long-term care or hospital admission. Local and flexible care, and its administration, work best. That's already been well-demonstrated.

I'd like to tell you a little bit about a local experience for our organization, and perhaps focus on one of our consumers—we call them consumers; they consume our services. We had the good fortune several years ago of an opportunity, working closely with our LHIN, to foster the idea of bringing home to one of our supportive housing programs a consumer who had been hospitalized and, to make a rather long story short, came to rely upon a ventilator permanently. It was proposed that our staff and our organization could fulfill the daily needs of this consumer, notwithstanding the fact that it had never been done before, at least in southern Ontario.

There were many naysayers. There were many people who quite simply refused to consider that option. We had our work cut out for us convincing the consumer involved that it could be done, but, with a great deal of encouragement and, obviously, the importance of administrative and financial support from the LHIN, we succeeded in bringing this consumer home.

This was home; notwithstanding this being a supportive housing program, it was home for this consumer before the hospitalization, and I'm happy to report that, after greater than two years, it has proven to be a wholesale success for everyone involved. It involved substantial training of our staff, and it involved getting past the hurdle of concern and worry. Empirically, we've demonstrated that it can be done and it can be done very well. This is all while achieving substantial savings of the cost had the consumer been required to continue to be in hospital care—very substantial savings.

We have since taken on the care of a second consumer that requires ventilator assistance. This was something that was unheard of even 15 years ago. It truly is a win-win for everyone involved. That, for me, is demonstrative, better than anything, of the value of community-based care, but it involved substantial cost. It involved a lot of work to ramp up to the point where we were able to fulfill this need.

Having said all of this, I submit to you that what has to come with the recognition of the value of increasing home- and community-based care is to accept that funding for that sector must also increase. As a front-line service provider, Assisted Living's experience is that while the LHINs themselves have received increased funding for this endeavour, we believe that it has not paced the increasing need and the expansion of these services.

I also submit to you that it's vital in considering the role of the LHINs in our society that your role in reviewing the legislation and the regulations must include responsibility to seek efficiencies. That's your public responsibility, and that must by necessity include reduction of expenses where it can be found, but it is our

submission that that should not be done while losing sight of the need to increase the ability of service providers to implement a strategy of cost-effective home care, because we are under-represented in that sector now. We remain so. It's a relatively new concept. Quite simply, what we're saying is that this means funding needs to increase substantially in this sector in order to achieve the goal of overall efficiency in health care.

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With the implementation of any new strategy, there are certain costs that must be incurred, including new or increased administrative costs. Somehow, in this equation, that has not been properly recognized, and it's our belief that somewhere in the flow, the LHINs have not been armed appropriately to address that. It's inherent to the success of implementing this strategy that resources be allocated to the LHIN appropriately to engage community health providers to achieve this goal.

Trained, capable and caring workers are also vital to this endeavour. Greater funding is needed to address the issue of disparity of wages for those workers. You only have to be a recipient of the service to realize, in general, how underpaid these workers are in our society when you consider the value of the service that they provide.

We have difficulty, as a service provider, attracting and retaining these trained, quality workers, because this is a relatively new strategy, and the funding is needed in order to ensure that there is an ongoing development and monitoring of criteria for that training. Hopefully, as that role expands, that need also increases.

I'm not going to take any more of your time, because my message is relatively narrow. In conclusion, I wish to submit to you, as a committee, in plain-speak, that in doing your job, in reviewing this legislation, in fulfilling your public responsibility to seek out efficiencies in health care, that you also consider where we need expansion, where there are efficiencies to be realized, yet those areas require additional, increased funding in going forward. It's part of that overall fiscal efficiency.

Having said that, I thank you, and I beseech you to do what is within your power to let service agencies like ours—and, for that matter, for-profit agencies as well have a role to play. Help us to continue doing our job and also to increase our ability to do the job in our community. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We just have time for one caucus. Ms. Cansfield?

Mrs. Donna H. Cansfield: Thank you very much for your presentation and good words of wisdom. I'd like to ask a question about the service providers: for example, PSWs.

Mr. Leo Muzzatti: Sure.

Mrs. Donna H. Cansfield: Job descriptions are fairly narrow. When I look at home care, I look beyond the individual. For example, is there food in the refrigerator? Is the toilet clean? It's that sort of holistic approach. How can we integrate that into when the worker comes into the home? Because currently, I'm told by my PSWs, if they were to go out and get bread or milk when the fridge

is empty, they'd be fired. How do we get around those and look more holistically at the needs of the client as opposed to the siloed effect of the individual support mechanisms?

Mr. Leo Muzzatti: I can assure you that if you go from agency to agency, you're probably going to find a different job description in different environments. But what I would suggest is that what you are likely seeing is the product of limited funding. What I suspect is that there is a focus on the personal care component, and it's a question of limited funding to allow all of the assistance that might be needed with the everyday tasks of daily living. So I suppose that for most agencies, if you have to choose one or the other, the focus, in all likelihood, is going to be personal care. But I can tell you that, certainly within our agency, our job description includes the very tasks that you're describing.

It really comes down to, in our case, allowing our consumers to decide where the resources—and by that, I mean the hours of service that we can allocate—where they want to expend them. If they have a priority on tasks like that, we will do everything in our power to achieve it.

Mrs. Donna H. Cansfield: So it does speak to a standard of care.

Mr. Leo Muzzatti: It does.

Mrs. Donna H. Cansfield: Thank you very much.

Mr. Leo Muzzatti: You're welcome.

The Chair (Mr. Ernie Hardeman): Thank you. Any further?

Mr. Mike Colle: Just one quick question: It's on administration. I guess the general public thinks that you just get the doctor, the nurse, the primary care out there and the PSW, but they have no appreciation—because again, they're busy—of the fact that you need these front-line workers to be directed and to be efficiently deployed.

Mr. Leo Muzzatti: Absolutely.

Mr. Mike Colle: Yet there's no appreciation of having to fund that part of it. The doctors get paid well; meanwhile, the unsung people behind the scenes are doing all the arranging. Is that what you're trying to say with that administration piece?

Mr. Leo Muzzatti: Well, if I take the example I gave you of the vent-care consumer, our staff were providing a lot of the services that are daily requirements for that particular consumer that, had they been delivered in a hospital setting, would have been vastly more expensive. Our workers, quite simply, are paid a great deal less than high-level nursing staff, and yet many of the functions that would have been performed if that consumer had remained in hospital would have been straightforward tasks of daily living that don't require that high level of nursing or medical attention.

The reality is that we can deliver it for a great deal less. The question is, when I think about some recent comments, for example, from the Premier, about where we want to go with the minimum wage, I would suggest to you that the average wage of a PSW in this province is not a great deal higher than that objective. Somewhere, there ought to be a happy balance.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It is much appreciated and helpful in our deliberations.

Mr. Leo Muzzatti: Thank you very much.

CHATHAM-KENT HEALTH ALLIANCE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Chatham-Kent Health Alliance: Colin Patey, president and chief executive officer. Thank you very much for being here. We very much appreciate you taking the time to come and talk to us. As with all our other presentations, you'll have 15 minutes to use as you see fit. You can use any or all of it. If you leave some time at the end that you don't use, we will have questions from the committee to fill in that time. But right now, you're in charge of the next 15 minutes.

Mr. Colin Patey: Well, thank you very much. Good afternoon, and thank you for coming out to this region. I thank you for this opportunity to address the Legislature's Standing Committee on Social Policy during this review of the Local Health System Integration Act.

I believe organizations like the OHA will be able to provide more depth and a broader perspective on this legislation than I can, but in my own experience, I've dedicated my entire career to health care administration. I've spent time in the public sector and the private sector in different provinces of Canada and, in fact, I've worked overseas in the UK.

I have two main objectives for participating in this process. The first is to affirm my view and support for the principles embedded within the act—that is, the principle that a local entity, not one centred in Toronto, can enable better access to quality health services, co-ordinate the local health system, and support effective and efficient management of the system. You see, I see it as we providers are the instrument and players, and the LHIN is the conductor of the symphony.

1320

My second purpose is to indicate the key area that, in my view, is the act's greatest limitation: where it is left open to potentially fail the system planning and integration it aims to achieve, and in doing so it may also fail patients. This point relates to the scope of authority, either through devolution or in the definition of defined health service providers in the act.

As set out in the legislation, LHINs can and should plan, fund and integrate the local health system. Therefore, I am here today to affirm that the act offers all of us—providers, clinicians, patients and communities—a tool to enable system transformation. However, it also has some limitations, which may compromise the potential intended, if not explicitly stated, in the legislation.

First and foremost, I want to provide greater detail on the strengths of the act. The principles embedded within the legislation reflect the need for local participation, dialogue and co-operation to plan and set local health care priorities. LHINs help to create local relationships and opportunities for shared planning, patient outcomes

and successful system transformation. A local, decentralized approach to health system planning embraces, importantly, flexibility in addressing differences across regions and communities and creates a more responsive entity to support and enable change that anticipates and addresses emerging needs. I offer the challenge to anyone to demonstrate that this can be done as effectively through a centralized ministry.

In my own organization, the Chatham-Kent Health Alliance, we have benefited from our relationship with the LHIN and other health service providers to enable change. A few examples include: a shared capital planning submission with two community-based partners, which recognizes the need to develop facilities and service delivery across—across—organizational boundaries. This work created a voluntary integration—a divestment of sorts—of select outpatient services to the community health centre, as one partner, and also created a fully integrated mental health management team between our hospital and a community provider, the Canadian Mental Health Association Lambton Kent. The latter of which is, as we understand it, the first of its kind in Ontario—much to be emulated, I believe.

On a more practical and operational level, having a local entity responsible for funding allowed us to negotiate a balanced budget waiver of \$1.5 million last year, which we delivered at \$1.2 million. This enabled us to implement at our own pace—and a sensitive one to our employees and patients—much-needed changes to reduce the challenges and operational constraints we continue to face as we migrate through the health system funding reform, which I'm sure you're well aware of. As a CEO, this is something that I value: the expectation for high performance on an ongoing basis but, when the circumstances necessitate, support and action that provide long-term solutions while mitigating the short-term impact of provincial policy change on local providers and patients.

On many occasions, having a local entity to speak with about system challenges and opportunities creates benefits for providers and patients alike; however, as I have also indicated, the act may require some adjustments or the fulsome support of the ministry to be the effective enabler of system transformation which Ontario requires.

On to my second point: I believe there is an inherent weakness either in the legislation or in its execution. This weakness can be attributed either to the fact that there has been little, or not enough, devolution of authority to the LHINs, or it may simply be that the definition of health service providers affected by the legislation and accountable to the LHINs requires revision.

In either case, it is my view that in order to fully execute the intention of the legislation, a LHIN must have the appropriate scope of power and authority to realize system transformation as intended, as I read and interpret part I, section 1, "Interpretation: Purpose of the act." It remains a mystery to me and to many of my colleagues as we chat how LHINs can be the enabling entities the system requires without having the accountability for all aspects of the local health system. LHINs

should have authority for all primary care. System design and delivery cannot be achieved when a vital component such as primary care is left outside. It's not a system; it's a non-system.

Understanding the roles and responsibilities between the LHIN and the ministry is difficult for us who have been engaged in the system for decades. The legislation opens the door to expanded power through devolution of authority; however, it appears to be a clause that is in place but not one that is readily practised. If it is not going to be used to support system transformation, then it would be helpful if the committee considered the definition of health service providers to be amended to reflect the local providers that are critically important to the system yet are not treated inclusively in the legislation, particularly all providers of primary care, of which the current legislation, it is my view, only identifies CHCs. However, the majority of our patients in our community are served by organizations like the local family health teams for primary care, but they fall under a different authority.

I ask the question, who is responsible for the broader aspects of population health? Will this emerging concept be aided by a further delineation, an outline of the responsibilities of the ministry and the LHIN, and through this act?

In Chatham-Kent, we are fortunate to have a community where all providers, including our family health teams, collaborate to improve the system and quality of patient care. My point is simply that this may not be the case everywhere, and thus the legislation may impede rather than enhance the systems integration it is intended to drive. It seems logical that having a consistent set of rules and one local body of authority for approvals would expedite such changes. Recognizing that the change of a system is difficult and likely to be done incrementally, this appears to be one mechanism to broaden accountability without encroaching on other jurisdictions such as municipalities, who have responsibility for ambulance services, as one example.

It is my hope that as the committee works through its review, it gives great consideration to how adjustments to the legislation can support the system transformation that we all recognize is needed and that many providers, such as my own organization, are already supporting to the extent possible within the limitations of the legislation.

There are many other areas within the legislation that we could consider, but with limited time I have chosen to focus on what I view as the greatest strengths—the principle of local planning, funding and integration—and the significant limitation of a lack of inclusivity of key partners within the definition or execution of this legislation.

That's my submission, and I thank you very much.

The Chair (Mr. Ernie Hardeman): Well, thank you very much. We have just over four minutes, so we will try and split it. We start with the third party.

1330

Ms. Teresa J. Armstrong: Oh, sorry.

The Chair (Mr. Ernie Hardeman): Ms. Armstrong?

Ms. Teresa J. Armstrong: I wasn't sure if we were first.

Thank you very much, Mr. Patey—is it Patey?

Mr. Colin Patey: Yes, it is. A good Newfoundland name.

Interjection.

Mr. Colin Patey: Oh, you bet.

Ms. Teresa J. Armstrong: Thank you for your presentation. One of the things that you suggested was to expand the power of the LHINs.

Mr. Colin Patey: The scope, yes—

Ms. Teresa J. Armstrong: The scope.

Mr. Colin Patey: —of authority and responsibility.

Ms. Teresa J. Armstrong: Right. And one of the suggestions you had talked about was including primary care in that scope.

Mr. Colin Patey: That is a correct interpretation, yes.

Ms. Teresa J. Armstrong: Okay. Do you see any roadblocks or barriers in doing that, or do you think that that's something that is feasible, that can be done?

Mr. Colin Patey: Well, there would be any number of barriers, but it's an opportunity to take on what those barriers and challenges may be. Importantly, the broader picture is that we need to get past the silos in which we work and to look at the system as a whole, seek what's best for the patient, who needs to be at that centre, find efficiencies across multiple providers, and deliver value for the taxpayer of Ontario. For instance, you may know very well that if primary care centres aren't open on social hours, they're going to end up in the emergency department, and that's the last place they should be.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. To the government: Mr. Colle.

Mr. Mike Colle: Thank you for your very decisive presentation. As you know, there are people still advocating going back to the centralized system—you know, the old regional health units and doing things from Toronto again—saying that getting rid of the LHINs gets rid of administration, so by going back to the old system we'll get rid of the middleman and just deliver health care more efficiently that way. What do think of that postulation?

Mr. Colin Patey: Well, there are many roads to get to Rome, but—for instance, you can go to a place like Ireland. They really have two health care boards to manage their entire system: one for quality and one for operations. That's one model that works in Ireland. We know that there are different organizational delivery mechanisms across this country, but I think that I put forward just a few of the views that very much support a local organization.

Now, I don't know if it should be 14 or 17 or 12—there are factors you would put into that to say how many LHINs you do need based upon patient referrals, population and geography—but I do know the principles of having a local organization who can respond flexibly to our needs and would know what our patient needs and organizational needs are on a local basis. It's the best

way in order to be able to customize the health care delivery service that looks after the patient and maximizes the limited taxpayer dollar that we do have.

The Chair (Mr. Ernie Hardeman): Thank you very much.

Mr. Colin Patey: A rose by any other name.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Nicholls?

Mr. Rick Nicholls: Thank you, Chair. First of all, Mr. Patey—Colin—it's good to see you, and I'm glad to see that Zoja is here with you today as well—and again, publicly to thank you for the opportunity I had to do some job shadowing in the ER at Chatham Kent Health Alliance.

Now, knowing you as I do, I know that you're far more solution-oriented to the challenges that are facing CKHA. What would you say would be one of the greater challenges facing CKHA and your relationship with the Erie St. Clair LHIN, and then, what would you suggest a solution to that greater challenge might be?

Mr. Colin Patey: We as a hospital deal with the failures of the health care system to keep people as healthy as they can be for as long as possible. There's an emerging concept called population health. Training in some of the universities—physicians and others—is emphasizing more on prevention and training our doctors that way. There are certainly more health care practitioners emerging who are dealing with the holistic matter of the human being and, frankly, keeping them healthy for as long as possible.

That's the future. That's the challenge: How does government and a public-funded health care system deal with population health, when it has some of its bodies that it holds accountable for parts of that—how does it migrate to a more holistic, inclusive and comprehensive approach for our citizens—to address that issue of prevention and keeping people healthy for as long as possible and staying out of—by institutions? Because that's a failure.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. For the committee's information—I'm sure you noticed—it went slightly over what we should have, but it was the last one of the day, so I didn't want to leave any good information behind when we came all the way to Windsor to hear it. So thank you very much for your presentation.

I thank everyone on the committee for all the hard work that you've done in the past four days to get us this far. We look forward to proceeding with this process next Tuesday in Timmins—no, Sudbury.

Mr. Mike Colle: Thunder Bay, isn't it?

Interjections.

The Chair (Mr. Ernie Hardeman): No, Sudbury is first; Thunder Bay is second.

Anyway, is there anything else for the good of the committee or, they say, for the good of Rotary? If there's nothing else, we're adjourned.

The committee adjourned at 1336.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Tuesday 4 February 2014

Journal des débats (Hansard)

Mardi 4 février 2014

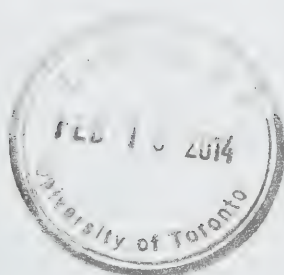
Standing Committee on Social Policy

Local Health System Integration
Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local

Chair: Ernie Hardeman
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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 4 February 2014

Mardi 4 février 2014

The committee met at 0907 in the Radisson Hotel, Sudbury.

LOCAL HEALTH SYSTEM INTEGRATION
ACT REVIEW

INDEPENDENCE CENTRE AND NETWORK

The Chair (Mr. Ernie Hardeman): Good morning. We'll call the Standing Committee on Social Policy to order. We're here to do the public hearings on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act. We're here to hear deputations.

I see we have the first one, the Independence Centre and Network: Marie Leon, chief executive officer. Thank you very much for being here this morning to make a presentation. We appreciate you giving us your time. You'll have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left over, if it's less than four minutes, we will have just one party ask questions. If there are more than four minutes left, we'll divide that time equally between the three parties, but that doesn't have to direct you as to how much time you have to leave. Thank you very much for being here. The next 15 minutes are yours.

Ms. Marie Leon: Thank you. Good morning. I'm honoured to be speaking to this committee today. My name is Marie Leon. I'm the chief executive officer at ICAN, the Independence Centre and Network.

We've been providing community support services for 35 years in this community. Our original mandate was to support adults with physical disabilities. In recent years, we've expanded our services to include high-risk seniors. Currently, we have about 130 employees and about 150 clients. Our budget is approximately \$5 million, and 90% of our staff have a PSW background.

Our programs include: an independence training centre for persons with physical disabilities; a post-stroke transitional program; supportive housing for adults with physical disabilities; enhanced congregate care for persons who have been deemed ALC in hospital; outreach attendant care services for persons with physical disabilities; and assisted living for high-risk seniors.

The local health integration network was created in 2006 with a mandate to plan, fund and integrate health care services for more efficient care in their regions. As with any major change, when the North East LHIN was

introduced, it created a lot of uncertainty for health service providers. With a name that included the word "integration," there was a lot of fear that the LHINs were created to integrate, merge and amalgamate smaller agencies like ICAN. This fear created a lot of mistrust within the health care sector and a lot of turf protection.

Over the past eight years, the North East LHIN has worked very hard to create a health care system built on partnerships and collaboration, always with the needs of clients in mind. ICAN has always been supportive of the reasons why the LHINs were created. Having local planning and accountability is a solid idea. I think it is especially important in northeastern Ontario, where our population and demographics are much different than in southern Ontario. Having northeastern Ontarians planning for northeastern Ontarians just makes sense.

There are some who would support the dissolution of the LHINs. This would not improve the health system right now and will distract from the more immediate issues relating to the delivery of home and community care.

ICAN has always had a very positive and supportive relationship with our LHIN. Our LHIN has recognized that community support service agencies like ICAN are part of the solution to our health care issues. Our LHIN has recognized that ICAN has a huge part to play in this.

Since its inception, the LHIN has funded many new programs and expansions of programs at ICAN. The LHIN funded the expansion of our supportive housing program into a second location. It funded the expansion of our outreach attendant care program into Sudbury west. It funded our enhanced congregate care program and our post-stroke transitional program. It included ICAN in the rollout of the new assisted-living program for seniors.

We have received outstanding support from the LHIN officer assigned to our agency. She is very knowledgeable about our sector and has been very supportive. She makes herself available whenever questions are raised and provides honest and transparent answers.

Generally, agencies like ICAN are struggling with recruitment and retention of our front-line workers who are mostly PSWs. A few years ago, our LHIN undertook a study and produced a report about the health human resource issues. There were several recommendations in the report. However, these recommendations were never implemented. This is a major issue for the community

support sector, and we would appreciate more support from the LHIN and the government on this.

Consumers of community support services are growing frustrated with turnover and the number of support workers being sent to their homes. The constant costs of recruitment and training new employees is immense.

We understand that retention isn't always about dollars and cents, and ICAN has made a point to strive for staff retention and staff satisfaction through various human resource means. However, offering a competitive wage is imperative to keeping quality staff with community support service agencies.

We are also struggling with the 0% increases to base budgets. For the past two years, the government has announced increases of 4% or 5% to community support services. Agencies like ICAN welcomed that news, only to learn that those increases were for new programming only, with the bulk of money going to the CCACs.

Community support service agencies are recognized as a solution to the health care issues, and we are being asked to support more and more people within the community. But we are being asked to do this on a crumbling foundation. This is no different than building new roads while leaving the existing ones to disintegrate.

The community needs more workers, but the community cannot pay our workers what they're worth. This results in high turnover and related expense as our workers move on to long-term-care homes and hospitals which, on average, pay their workers about \$5 an hour more.

I would ask everyone to consider this question: Do you think \$16 an hour is enough to pay for someone to look after your loved one? Do you think you could support your family on \$16 an hour? We look to the LHIN to support us in talks with the ministry by advocating for our need for additional base funding.

The North East LHIN has had its share of growing pains. It is not perfect, but it continues to evolve and improve. Some of the LHIN funding decisions have been hard to manage. The original funding for the new assisted-living program for high-risk seniors is not sufficient. The consumers are crying out for more services, and because of the funding formula, our hands are tied.

Until recently, any new funding did not allow for any administrative expenses. This is becoming overwhelming for some smaller agencies. Reporting requirements have grown to include the ministry, the LHIN and, in some cases, the CCAC. A new provincial standardized client assessment tool has been implemented, with no additional funding to cover the ongoing cost of doing these assessments. Our LHIN has heard our concerns regarding these funding inequities and is working hard to address them.

Communication between the North East LHIN and service providers has also been challenging at times. Considering the huge geographic area and the diversity, this is not unexpected. For example, the North East LHIN has increased its engagement with providers, but with it comes more meetings, more committees and more

resources to take part, especially when there's travel involved.

The LHIN has also become much more responsive to questions. However, there's still room for improvement. As I reported earlier, our officer is very quick to respond to emails or phone calls. However, others at the LHIN are very slow to respond or do not respond at all.

As already mentioned several years ago, a health human resource report was developed by the LHIN with several initiatives to address the ongoing PSW crisis. ICAN is still awaiting word on the next steps.

The LHIN's staff seems to keep growing, with new positions being posted on a regular basis. There have been times when the same question has been asked of different staff at the LHIN and we have received different answers. This causes confusion and uncertainty.

The LHIN implemented the expanded role of the CCAC, which included managing some of the community support service wait-lists. Some providers felt forced into these changes without a lot of input.

The LHIN is also working hard at improving communication throughout the sector. It's very nice to know and recognize the LHIN representatives at meetings and within the community. It is also very beneficial to be able to have frank and earnest discussions with the LHIN regarding our issues.

Is our LHIN perfect? No. Is our LHIN getting better? Yes. Is there room for improvement? Always. Does the LHIN recognize this? Yes. Does ICAN support the LHIN? Yes. Is our health care system headed in the right direction? Yes.

In closing, the North East LHIN understands the health care system, which includes hospitals, the CCAC and the community. It understands our diverse region. The LHIN promotes partnerships and understandings between all of the stakeholders in the health care system. The North East LHIN is committed to improving our health care system and sees the importance of keeping people living independently in their own homes. It recognizes the need to invest in home and community care, which will free up hospital beds and the emergency department and will decrease long-term-care placement. ICAN supports the North East LHIN and would not want to see it replaced with something else that does not have local control or input.

Although it may seem that the LHIN has been in place for a long time, transforming a whole health care system takes a lot of work and a lot of time. I ask that you give the LHINs the time they need to continue this important work.

Thank you for the opportunity to speak.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have four and a half minutes left. With that, we will start with the government. Try to keep it within a minute or a minute and a quarter. Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming. We've certainly heard the PSW piece that you have articulated. We heard that in southwestern Ontario also.

I'm sure that our government will take a very strong look at that.

You talked about an officer from the LHIN who is assigned to you. Are you involved in any other sort of committee or council? We heard from the South West LHIN about something they've developed: the Health System Leadership Council. Is there any kind of forum like that that you might be a part of up here?

Ms. Marie Leon: For the community service sector, we do have a regional committee, which I sit on, and there's a representative from the LHIN on that committee. We also have a local committee, which is also well represented by the LHIN. So yes, they do sit on various committees throughout the northeast.

Ms. Helena Jaczek: So you're able to—

The Chair (Mr. Ernie Hardeman): Thank you. The official opposition.

0920

Mrs. Jane McKenna: Thank you so much for coming. It was a wonderful presentation.

I have a question. You had mentioned about the expansion and the monies that you had received from the LHINs to do that. I'm just curious: How do you measure the outcomes of what you've been given the monies for—if it has worked, if it has been put in the right place—because sometimes just giving money doesn't mean it was the right place to put it. So where was the strategy behind that?

Ms. Marie Leon: The new money that I was talking about for assisted living for frail seniors—we were the first to pilot it in Sudbury, and it was a new program, so in all fairness we were all learning. When we got the funding, it was based on us taking on 15 clients, with an average of two hours of service. Through key performance indicators, it has become clear that clients in that program need an average of four hours a day. So we're hearing from the clients.

The LHIN has actually set up, through a committee, some key performance indicators that we're measuring, including hospital emergency visits. So there's a lot of data to support that. It has been presented back to the LHIN, and they're recognizing that there has to be a tweak to some of that. Instead of holding us to 15 clients, they're now saying that it's based on hours of service. So instead of giving everybody two hours of service, we're able to give someone who needs six hours of service what they need. The LHIN has come through on that, and we're getting there.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Gélinas?

M^{me} France Gélinas: I don't know if you are able to give us a bit of a comparison. You've explained some of the challenges with recruitment and retention issues because of salaries and others. You've explained some of the challenges with meeting the growing needs of the population you serve. Can you balance the fact that you're able to work with LHINs versus had you had to work with the regional office of the Ministry of Health?

How has that relationship changed to try to solve the issues that you're struggling with right now?

Ms. Marie Leon: As I said, in communication with the local officer, they get it. They know our demographic. They see it; they hear it from everyone.

M^{me} France Gélinas: Do they visit your agency?

Ms. Marie Leon: Yes, absolutely. From the senior officer right up to the chief executive officer, they have visited; they've toured. They've met with some of the clients. They're definitely engaged and plugged into our sector.

M^{me} France Gélinas: Do you feel that because they're more hands-on and are located in the north, a solution will come, as opposed to what we had before with the regional office?

Ms. Marie Leon: I'm hoping. I still hold out hope that the initiatives identified in that report will be followed through on. I think it goes up to the ministry level and the funding level: Are the LHIN's hands tied in addressing this as well?

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is the North East Local Health Integration Network: Louise Paquette, chief executive officer. I understand that we're going to have a PowerPoint presentation, some of which is in French.

Ms. Louise Paquette: Oui. Yes.

The Chair (Mr. Ernie Hardeman): So I just remind the committee that you have your translation devices on the table, if you wish to partake of that.

Thank you very much for being here. As with the previous presenter, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's time left over and it's more than four minutes, we will divide it equally among the three caucuses. If it's less than four minutes, it will be one caucus that gets the opportunity to ask a question. With that, the next 15 minutes are yours. Thank you.

Ms. Louise Paquette: Thank you. Bonjour. Hello. Aanii. My name is Louise Paquette and I'm the CEO of the North East LHIN.

What can I tell you today that will help you in your review of the LHSIA legislation as you consider the scope of responsibilities and authorities of the LHINs? I appreciate the opportunity to provide a northern perspective, and I would like to begin by introducing you to one of our elders: 109 years young, Marguerite Wabano. Born into the Attawapiskat First Nation, she is not only the oldest residential school survivor but one of the oldest seniors whom we, as a LHIN, are supporting at home.

I first met Granny Wabano, as she is affectionately known, in the Weeneebayko area hospital in Moose Factory. She had just showered and was getting ready to go home. The last time I saw her, she was playing bingo

at the Elders Gathering Place in Moosonee, where I met up with the Red Cross workers.

As a LHIN, we work closely with the Red Cross, and having supported the gathering place, I wanted to see the results of our collected efforts myself. On my most recent visit to the coast, I was accompanied by three geriatricians: Dr. Samir Sinha, the provincial Seniors Strategy lead; Dr. Jo-Anne Clarke, the clinical lead for the North East Specialized Geriatric Services; and Dr. Janet McElhaney, the medical lead for seniors' care at Health Sciences North. We visited five coastal communities, talked to health service providers and listened to elders. Here's a copy of the report.

As a result of this visit, the North East LHIN responded with very tangible items, like more foot care funding—coastal communities have one of the highest rates of diabetes in Ontario; a wheelchair for the health centre in Peawanuck; and two vans to help transport elders in Kashechewan and Attawapiskat.

More recently, two weeks ago, these same geriatricians, accompanied by a team of allied health professionals, returned to Fort Albany to do clinical work. They developed a geriatric assessment tool specifically for aboriginal people and individualized care plans that local workers will implement with ongoing support through telemedicine. To ensure proper follow-up, the North East LHIN has worked with the Red Cross to provide personal support worker training. Today, 24 students—many of them women with children—are receiving training in their community. As you can imagine, given the shortage of health care professionals, this grow-your-own program is filling a gap and providing both education and jobs in an area with low employment. You see, there are no long-term-care homes on the coast, so building a system of care that is culturally sensitive and acceptable to the people who live in these coastal communities requires a regional model that promotes flexibility and an understanding of local circumstances. That is why our 12-member Local Aboriginal Health Committee, with regional representation, is a critical sounding board in our decision-making process.

Recognizing that a community's health needs are best understood by the people who live there, community engagement is the cornerstone of the LHIN model. During the development of the North East LHIN's most recent Integrated Health Service Plan, we engaged with over 4,000 northerners, including patients, providers and the general public. Because of our huge geography and the importance of being accessible, the North East LHIN has staff in Sudbury, Timmins, North Bay and Sault Ste. Marie, and we engage across communities on an ongoing basis, actively participating in community events, Rotary and other service club meetings, annual meetings and public forums. Every day, LHINs work to break down traditional silos, bring people together and connect health service providers.

Here at the North East LHIN, we are blessed with exceptional health care workers who provide care to the 565,000 people who live in this vast geography that ex-

tends from Peawanuck to Parry Sound and from Mattawa to Hornepayne and all points in between. While geography is a particular challenge in our LHIN, so too are the facts that people are living longer with more complex conditions and our population is declining, particularly in our remote communities. Our job at the North East LHIN is to work with our 148 health service providers, including 25 hospitals, 41 long-term-care homes, 48 community mental health and addiction agencies, 63 community support services, six community health centres and our North East CCAC. Together, we are rethinking how care is delivered. For the most part, these organizations operate independently of each other and do not assume responsibility for transitions of care, particularly when a patient moves from hospital to community.

Comme planificateur du système local, le RLISS du Nord-Est se penche sur les transitions entre les milieux de soins axées sur les besoins des patients et non des organismes afin d'offrir aux gens du Nord l'accès aux soins appropriés au bon endroit et, comme l'a bien dit l'un de mes concitoyens francophones, « dans la langue de mon choix. » Étant donné que les francophones représentent 23 % de la population de notre région, le RLISS du Nord-Est travaille étroitement avec l'entité de planification des services en français, le Réseaux du mieux-être francophone du Nord de l'Ontario; maintient le dialogue avec les francophones; et collabore avec les pourvoyeurs afin qu'ils obtiennent leur désignation indiquant qu'ils offrent des services de qualité en français.

Notre RLISS a multiplié les services de soutien communautaire, les programmes de jour et l'aide aux transports pour les personnes âgées francophones, particulièrement dans les régions de Nipissing Ouest, Chapleau, Témiscamingue et l'est de Sudbury.

J'aimerais vous présenter Elizabeth Lamirande : femme avant-garde, elle a été la première femme à conduire un autobus pour la compagnie Sudbury Transit. M^{me} Lamirande était une patiente en attente d'un autre niveau de soins depuis neuf mois à l'ancien site de Sudbury Memorial avant d'être admise aux soins de longue durée. Sa santé s'est améliorée grâce aux soins qu'elle a reçus au Manoir des pionniers. Il ne lui manquait que son autonomie.

0930

Today, Elizabeth lives in an assisted-living apartment in Sudbury, at Finlandia Village, which the North East LHIN recently provided with additional funding. In fact, we have added close to 230 new assisted-living clients to the system over the past two years. From acute care to long-term care to assisted living—this is a good example of how a person can move across and through the system, considering that being discharged from long-term care was virtually unheard of in the past.

But for LHINs to provide the much-needed service of assisted living, there needs to be infrastructure in the form of housing. This is where the cross-ministerial, jurisdictional and community conversations are crucial.

The LHIN is a system planner, not a provider. I trust our providers because I have great faith in people, but with trust must come transparency and accountability. That is why all of the LHIN funding is provided to health service providers through accountability agreements with specific deliverables, metrics and performance indicators.

We work closely with our providers because individual performance often has a ripple effect on system performance. For example, when I started as CEO of the North East LHIN four years ago, the rate of alternate-level-of-care patients in our regional hospital, at Health Sciences North, was hovering around 40%. With this high ALC rate, surgeries were being cancelled regularly, wait times in the emergency department were unacceptable and there was gridlock in the hospital.

The North East LHIN brought community and municipal leaders, physicians and health care partners together to develop a plan, targeted community investments and commissioned a peer review of Health Sciences North.

We also successfully worked with the ministry to overturn the commissioners' decision to close the Memorial site, which has now become the Sudbury Outpatient Centre. Sudbury needed this outpatient clinic capacity to address the chronic conditions of its aging population.

In addition, last year the North East LHIN brought together the Canadian Mental Health Association, the Greater Sudbury Police Service and the hospital to address the needs of a special population. A strong health care system is not built by those working in health care alone. Healthy communities are safe communities, and the North East LHIN sees our local police departments as vital partners.

This is Arvind Jagessar, a consumer who was at the launch of the community crisis centre in Sudbury in the fall of 2012. Arvind talked to me about not wanting to be around a lot of people in crisis, especially in the emergency department. He felt this new model, which relocated all crisis intervention services from the hospital to a calmer environment in the downtown core, would help people suffering from mental health issues.

Since the centre opened, not only has there been an 18% decrease in the number of people with mental health issues going to the emergency department, but people are getting the right care at the right place.

With the police officers receiving new training, there has been a marked decrease in the number of apprehensions under the Mental Health Act, and less time spent by officers in the emergency department, with an estimated two more hours a day devoted to front-line policing.

While it's still a work in progress, the average ALC rate at HSN is now fluctuating around 20%. There has been improvement in ER wait times, better discharge planning and improved transitions of care.

In June 2010, we commissioned a peer review of the Sault Area Hospital, which, at the time, held the second-worst deficit in the province of Ontario, at \$12 million. Today, not only is the hospital budget balanced, it is

achieving a surplus. In fact, today, all four of our large hospitals have balanced budgets.

As we move from global funding to a model where funding follows the needs of the patient, the North East LHIN is completing a clinical services review of all 25 hospitals in order to better understand the impact of these changes on northerners and develop a plan to support the transition.

Understanding northern Ontario's economy and our history are an integral part of the health care conversation. As the producers of mineral wealth and lumber for Ontario, over time, northern Ontario responded to the needs of miners and lumberjacks by building local, small hospitals and providing the best treatment available at the time.

Take, for example, Sensenbrenner Hospital, built in 1929 by the Spruce Falls Pulp and Paper Co., and consider that Mattawa General Hospital was built in 1878, when the average life expectancy was just over 40 years of age. Today, the CEO of Mattawa Hospital is also the administrator of the Algonquin Nursing Home, an innovative approach to managing the health care needs of people living in this small northern community.

Back in the day, health care was hospital care. Our 21 small hospitals play a pivotal role in northern Ontario. We as a LHIN recognize their importance and are working with them to better respond to the needs of our aging population.

Many of these seniors are the pioneers of northern Ontario and live in communities where the population has seen double-digit decline. They live on their own, with little to no immediate family close by. The LHINs understand because they listen.

The North East LHIN understands the importance of helping people with dementia and their caregivers by providing specialized training to 5,500 front-line health care workers. This means that people like Violet Babcock can enjoy the music of Phil Collins when she's having a bad day at her long-term-care home.

The North East LHIN understands people like Rina Clark, who cares for her husband, David, a physics teacher who was diagnosed with Alzheimer's in his early sixties. She asked the LHIN to enhance the hours of the local adult day program, which was only offered three days a week. Today, this program is available six days a week.

The North East LHIN understands that when people are in excruciating hip pain, they need to get to the next available surgeon. That's why we created five joint assessment centres, where people are assessed by an advanced practice physiotherapist. Since starting these centres, we've found that 64% of patients don't need surgery but some other form of treatment.

The North East LHIN works with providers to improve transitions of care, because we understand the importance of helping seniors return safely from hospital. That's why we started a program called PATH, where a care worker from the Red Cross accompanies high-risk seniors home, picks up their medications, makes sure that

there's bread and milk in the fridge and that they are comfortably settled, with home care services in place.

Decentralized decision-making allows us to target our funding to meet local needs. I'm sure it comes as no surprise that in our community engagements, transportation is often an issue, given that we have hundreds of communities with no local public transit. So, in 2012, the North East LHIN responded by providing vans to support seniors in the Cochrane area, helping people maintain their independence and access care.

Sometimes, though, it's not about buying vehicles. Two years ago, we supported the creation of a mobile adult day program that travels to different communities on Manitoulin Island, and we are just finishing a study on non-urgent patient transportation that will truly be a made-in-the-north solution to that vexing dilemma of how to do non-urgent inter-facility transfers. Being a leader in health care today means having the courage to call into question the way things have been done in the past. That's what LHINs do.

I hope I have provided you with a northern perspective of the value of LHINs. Being one of the 14 networks, the North East LHIN benefits from the experience and best practices of others, and has the flexibility to adopt or adapt a good idea to better suit local needs and local priorities. We need to stay this course.

As a born-and-raised northerner, I understand the challenges, the fear of loss and the territorial behaviour of some providers. I know that small hospitals are often the heart and soul of their communities, but I have also heard northerners tell us loud and clear that the status quo is not an option.

Prior to joining the LHIN, I spent 25 years working in northern communities, delivering community economic development programs as the ADM for the provincial government and as the director general for the federal economic development agency.

I believe that the North East LHIN is key to helping fellow northerners develop a solution to ultimately answer the question, "How do you provide quality care to 565,000 people in a geography bigger than Germany, so that northerners can remain as independent as they want and receive as much care as they need?" Because, to put it bluntly, we don't want decisions about the delivery of our health care made by people who don't live here. As a LHIN, we listen and respond to people like Granny Wabano, Rina Clark and Arvind Jagessar.

Meegwetch. Thank you. Merci.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have slightly exceeded the 15 minutes, so all of your time is consumed. Thank you very much for being here.

Ms. Louise Paquette: Thank you.

NORTH EAST COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Next is the North East Community Care Access Centre: Richard C. Joly,

chief executive officer, and Ann Matte, senior director of quality and information services. Welcome.

Thank you very much for coming in this morning and sharing your time. As with the other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. At the end of the presentation, if there's sufficient time, we will have questions from the caucuses.

With that, the next 15 minutes are yours.

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Mr. Richard Joly: Thank you very much, Mr. Chair. Good morning to committee members. Bonjour, tout le monde.

Welcome to the heart of the province. My name is Richard Joly. I'm the CEO of the North East Community Care Access Centre. With me today is my colleague Ann Matte, senior director of quality and information services. Both Ann and I are registered nurses by profession, and we have worked in the health care field for a combined 50-plus years. We also bring a unique perspective this morning because at one point in our careers, we have each held senior positions with the North East LHIN.

From what we've seen this morning, we know that committee members have a busy agenda and are hearing from a number of presenters today, so let's begin.

First, I'm happy to report that the North East CCAC has a very solid relationship with the local LHIN. We support their system planning role. This includes bringing partners across the system to the table and engaging with patients and communities. This collaborative role is a critical component of any high-functioning health care system.

On balance, we believe that the Local Health System Integration Act works well and sets out a strong framework for local health system planning, funding and accountability. Our comments and suggestions this morning are intended to strengthen the current framework.

I'd like to take a few moments to clarify our respective roles within the health care system and then highlight a few examples of how we have worked together to improve health care services across the northeast.

Our mutual goal, of course, is to achieve a fully integrated, patient-centred health care system where the right care is offered in the right place at the right time and, of course, at the right cost. Although we share the same boundaries, the North East LHIN and the North East CCAC have very distinct roles within our health care system. Simply put, the LHIN is responsible for planning and funding the delivery of regional health services, monitoring health system performance and holding health service providers like the CCAC accountable for the quality and value of the care we provide.

As one of the largest health service providers in the North East, our CCAC plays a vital, critical role within the health care system as a whole. We are the coordinator of care for patients transitioning from hospital to home or from home to an alternate venue of care like assisted living, a retirement home or a long-term-care home. We provide in-home nursing, rehabilitative care and personal

support services to individuals who wish to live and age safely in their homes or recover after a stay in hospital. We also work with medically fragile children and individuals at end of life. Care coordination is our core service. It is not administration. It is patient care, and it is essential to any well-functioning system.

Ann will now share one of our patient's stories with you.

Ms. Ann Matte: Conrad was a fiercely independent, hard-working miner, self-employed construction worker and former service station owner, but then a series of medical setbacks set his life on a different course. In 1998, Conrad suffered a broken hip in an accident, and it was during his recovery that his multiple sclerosis was diagnosed. By the time he was 58, he found himself needing full-time care, with his mobility limited to a wheelchair.

Fortunately for Conrad, his wife of 46 years and his three adult children have been by his side every step along his health journey. But there are many heroes in this home, who came together to help Conrad maintain his independence and enjoy a happy and productive life.

First, a CCAC care coordinator worked with the family to develop a comprehensive care plan. Conrad currently receives therapy, assistance with activities of daily living and a monthly nursing visit. His personal support workers help him with his personal care and the daily exercises prescribed by his therapist. They are also able to monitor Conrad's MS and alert the nurse if they notice any new symptoms.

The care coordinator also provided the family with information about available community support services, and the couple now receives financial aid from the MS Society to help with many of the equipment costs associated with Conrad's illnesses.

Imagine one family trying to research, access and coordinate this level of care for a loved one, especially during a stressful time. As Conrad's wife herself writes, "Without CCAC services, I wouldn't be able to take care of my husband at home. It would be too much for me mentally, emotionally, and especially physically, even with the lifts."

CCAC care coordinators are often referred to as silo busters as they work with all health care partners—hospitals, primary care providers, long-term-care homes, community health centres and clinics, family health teams, hospices and more—to provide patients with seamless transitions from one health care destination to another, and to develop and coordinate care plans to meet individual needs. And we do it within a geography that covers 415,000 square kilometres, or approximately 42% of the province.

On any given day, we help over 16,000 individuals and families across our vast region, serving roughly 34,000 people each year. Each month, we help over 1,000 people come home from hospital with specialized services and support 200 seniors transition to long-term care, as you heard from Louise earlier. Our care coordinators work with all 25 hospitals and emergency depart-

ments in the North East. In Sudbury alone, we have 25 staff working on-site at Health Sciences North every day, 365 days a year. We work with more than 550 family physicians in the North East. We work with every school, every community agency and every long-term-care home.

As you can imagine, there are many unique challenges related to health care provision in northeastern Ontario. Residents often drive long distances to visit loved ones in hospitals or long-term-care homes, and home care workers themselves often drive long distances to provide services to patients. Specialized professional services are difficult to coordinate in rural areas, and wait times reflect these issues in both the acute and community settings. Yet, within this environment lies unique opportunity through technology and innovation, through leadership and integration, through the three big Cs: collaboration, coordination and communication.

Richard, would you like to continue?

Mr. Richard Joly: Thanks, Ann. The following are examples of current collaboration activities that have occurred in the North East, with the leadership and support of the North East LHIN. These activities have demonstrated and will continue to demonstrate efficiencies and improvements to the health care journey of people living in our region.

Just a few years ago, there were hundreds of patients in the wrong place: too many people in hospital beds, who no longer required acute care; and too many people in long-term-care homes, who could be better served with community supports like home care, adult day programs and assisted living.

Over the past several years, the North East LHIN has partnered with the North East CCAC and other health service providers to implement many system-level changes, including the very successful Home First philosophy; integrated discharge planning within our hospitals; new nursing programs in the community, like rapid response nursing; Telehomecare; and the province-wide physiotherapy reform.

With these changes, many service improvements have been realized, such as—you heard this morning—a decrease in the number of alternate-level-of-care patients in hospital, from 41% to 22%; increased complexity of patients to long-term-care homes, from 72% to 84%; a decrease in length of stay in long-term-care homes, from 3.5 years to three years; and a significant decrease in our placement wait-list.

As we discussed earlier, the North East CCAC's vast land mass can be a challenge to health care delivery, but it has also served as the perfect incubator for developing successful technological tools to bring health care to the patient.

Working collaboratively with its health service providers, the North East LHIN has developed a comprehensive technology strategic plan which has enabled and promoted innovation within our health care system.

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Here are just a few projects supported by the LHIN's strategic plan and led by our CCAC:

Last fiscal year, the LHIN provided funding to support a pilot e-notification project in Sudbury. The technology allowed the CCAC care coordinator working on-site at Health Sciences North to be notified electronically as soon as a CCAC patient presented themselves in the emergency department. The care coordinator would then meet with the patient and the family, before being admitted, to determine if the patient could return home with enhanced services. Due to the success of the pilot, which wrapped up just last month, eHealth Ontario has agreed to fund the expansion to 37 hospitals, through the North East and North West LHINs. Led by the North East CCAC, this work is scheduled to be complete by March 2015.

Another successful project is the Community Health Portal. The North East CCAC was the first to roll out the Community Health Portal—a secure website that allows health professionals outside of the CCAC to access a summary of patient information—to primary care providers. What began as a LHIN-funded pilot project with only three hospitals and three family health teams, the rollout will now expand to 74 health service providers, in coordination with both the North East and North West LHINs.

In conclusion, let me restate the obvious. Our population is aging. Our health care system is in the midst of a significant transformation to prepare for the future needs of our patients and our communities. We believe that LHINs and LHSIA provide the right foundation to support this transformation. Ultimately, regardless of structure, a common vision focused on the people we serve and a strong collaborative relationship are the key ingredients in making the health care system work.

The vast majority of people have good experiences with the care that they receive, but we know that the system doesn't work well for everyone and we can always do better. For example, there are hundreds of health service providers across the North East, each with their own administrative structures. Through back office integration and other shared service opportunities, efficiencies could be found and reinvested in patient care. LHIN and service providers should continue to explore opportunities for administrative efficiencies between service providers.

We also feel the delivery of health care in Ontario could be improved by a renewed focus on strategic regional health system capacity planning. Sections 15 and 16 of LHSIA require LHINs to engage their local communities and develop an Integrated Health Service Plan that sets out the vision, priorities and strategic direction for the local health system and strategies to integrate. We only need to look back at the significant disruption caused by the recent strike by personal support workers in the province to realize that planning for current and future human resource needs must be part of the capacity plan.

Here in the North East, we are walking the walk. Given the system-level changes that have been introduced to meet the care needs of the aging population and to maintain the gains made in our ALC rates across the region, we are working with the North East LHIN to initiate a third-party collaborative capacity analysis of our adult home care services. The goal of the analysis is to develop a multi-year plan to meet the home care needs of our population in the North East, while ensuring long-term financial sustainability.

Finally, I'd like to thank you for the opportunity of adding our voice to this important dialogue. The North East CCAC is proud of our role to deliver preventive, healing and palliative care in-home and in-community for the residents of our region. We will continue to recognize and support the North East LHIN's mandate in planning, funding and fostering collaboration between all our partners, to continuously improve our health care system. Thank you. Merci.

The Chair (Mr. Ernie Hardeman): Thank you both very much for your presentation—very informative—and we thank you for taking the time to present it. The time has been consumed, so with that, thank you again.

CANADIAN MENTAL HEALTH ASSOCIATION-SUDBURY/MANITOULIN

The Chair (Mr. Ernie Hardeman): We'll get on to our next presenter. The next presenter is the Canadian Mental Health Association-Sudbury/Manitoulin branch: Marion Quigley, chief executive officer. Thank you very much for being here this morning. We thank you for the time you took to come here. We have 15 minutes for each presenter. You can use any or all of that time for your presentation. If there's time left, we'll have questions from caucus.

With that, the next 15 minutes are yours.

Ms. Marion Quigley: Thank you, and good morning, everyone. I won't go into details about the Canadian Mental Health Association; I've provided you a package of information.

I am Marion Quigley. I'm the CEO of the local branch here.

Warren Bennis, one of our time's greatest authorities on leadership, is quoted as saying: "Leadership is the capacity to translate vision into reality."

At least one in three residents in northeastern Ontario experiences a mental health issue in their lifetime. Based on nationwide estimates in 2012 population figures, the annual economic cost of mental illness in the northeast is \$730 million.

In 2007, when the North East Local Health Integration Network began to lead the transformation of our deeply divided health care system, some of us working at the front line were doubtful and had many concerns. Would this transformation be focused on finances, or would quality and accountability be addressed to help our governance teams and staff in ways that mattered to real people? I can only speak for the Canadian Mental Health

Association's Sudbury/Manitoulin branch when I say that, though there remain many areas desperately needing change, the benefits of leadership being provided by the North East LHIN are making a significant difference in the lives of the clients we serve.

One of the many examples I could give, which directly relates to the increasing collaboration our branch is involved in, with the support or leadership from the North East LHIN, is the Moonlight residence story. In a relatively short period of time, as vision to reality goes in the world of project management, we were able to partner with the North Bay Regional Health Centre, the Northern Initiative for Social Action and Health Sciences North to open an eight-bed recovery home. The home provides sustainable, permanent housing to individuals previously living in hospital. This is not just a bricks-and-mortar story. It's a story of lives transformed. Without this collaboration, these eight people may have still been living in a hospital bed today.

There is much which remains to be addressed, however, in the transformation of our health care system. For the clients we see on a day-to-day basis, the remaining challenges can frequently be traced back to our still-in-silos system and the cumbersome processes many clients experience in order to access service. We still see individuals in the Sudbury-Manitoulin area who are struggling, often desperately, or completely unable to access services they require. This reality ranges from clients without access to counselling, to service gaps in affordable housing, to suicide prevention, and multiple other gaps in service. We in the sector must learn and be supported to combine our resources so that in that moment, for that individual considering that choice, hope wins over despair and we are there to prevent the results of a tragic and irreversible decision.

There are many areas where the momentum being built for a better system in the northeast needs to be supported. You will find those we feel need to be highlighted for the northeast in the handout we've prepared. To mention a few, they include the changes we need and would support, such as more investment in affordable housing; multi-year funding; increased investments to the community mental health and addictions sector; and increased authority for the North East LHIN in areas such as housing, public health and primary care.

As well, when mental health and addiction funding is given to a community agency to provide supports in the community sector, clients benefit. However, we must not forget that the community agency also needs to see increases in their infrastructure so the organizations can sustain services such as reception, secretarial, heat, hydro, rent, and remain viable organizations.

System planning and leadership, such as that being provided by the North East LHIN, is exactly what our clients need to continue the work which has begun. The CMHA Sudbury/Manitoulin has been, and is, working collaboratively with the North East LHIN and our community mental health and addiction partners on many initiatives.

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One key element we see contributing to the success of these collaborations is the accountability and quality piece. Since the LHINs began planning and funding, any new financing is attached to the requirement to show results. By collaborating, we have been able to meet our commitments in getting results with new funding.

One example is our successful partnership on the crisis program in downtown Sudbury that Louise mentioned. The program benefits from a mobile crisis component and a client navigator situated in the emergency room waiting area of the hospital. We heard from our clients, understood their needs, and partnered with Health Sciences North and the Greater Sudbury Police at the front lines. We are getting excellent results with better, more efficient access to urgent care for our clients living through serious mental health challenges.

With any newly proposed initiative, organizations are now challenged with the requirement to answer questions such as: "Is this the best place for the funding?" If this cannot be shown, then the North East LHIN explores how we can make sure that individuals needing services will get them. More often now, the result is that new funding is going to the community sector, to the street, to homes, where people actually live day to day. We are helping individuals navigate through the health, housing and justice systems, among others, and obtain services that meet their needs close to home whenever possible.

We are seeing increased equity in the focus for health care across our region. The emphasis is not just on urban areas. We're seeing it in our rural areas—Manitoulin and Espanola, in particular, where we only have one CMHA staff member in each community. They work in collaboration with staff from other organizations, collaborating together. The client, being seen for mental health and addiction services, doesn't even realize who the staff member helping him or her actually works for. It's truly a team with a client-centred approach. All the client cares about is getting help. The client doesn't care about the name of the organization or who's funding it.

Seventy-five per cent of mental health care happens outside the formal health system. The 2012 Commission on the Reform of Ontario's Public Services, the Drummond report, supports higher levels of funding for mental health and addictions to address what it terms as a "historic gap." The government of Ontario has highlighted the importance of enhancing mental health and addictions in the action plan for health care and the 10-year mental health and addictions strategy.

CMHA Ontario is calling for a further increase of 4% in the sector to address client needs.

Expert planning and leadership for collaboration is needed to effectively manage funding and ensure better outcomes for our clients.

The Ministry of Health and Long-Term Care cannot address the needs of northeastern Ontario persons with lived experience, as a stand-alone agency. The arrival of the LHINs heralds a more client-centred, needs-based approach. The North East LHIN's vision is "Quality

health care, when you need it.” It is the CHMA Sudbury/Manitoulin’s mission to continually improve community-based mental health supports to facilitate the well-being of all people. We know that the synergies of our two organizations are bearing fruit.

The North East LHIN is hearing the voices of our clients and providing the leadership required to further transform the Sudbury-Manitoulin area’s health care system. There is much left to do. The benefits of the leadership being provided by the North East LHIN are making a significant difference in the lives of the clients we serve.

On behalf of our clients and the board, the staff of the CMHA Sudbury/Manitoulin looks forward to a continued partnership with the North East LHIN in this historic transformation.

“Leadership is the capacity to translate vision into reality.” Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have two minutes for each caucus, starting with the official opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Ms. Quigley, for your presentation and for the great work that you do in our communities. I certainly agree with you that there is still much work to be done to have mental health being recognized as being equally as important as physical health, but we’re making some progress.

You mentioned that there was still a lot of work to be done, that you are working collaboratively with the LHINs. Can you tell us what you’d like to see as a next step in that process?

Ms. Marion Quigley: I think for us as an organization, personally, it’s to give the LHIN the authority to manage the housing portfolio, from the Ministry of Health and Long-Term Care. Sometimes it’s difficult to work with two organizations, because they take care of the bricks and mortar, and the LHIN takes care of the people and the health care portion.

Mrs. Christine Elliott: So it’s more of the integration of the housing and social services piece into the work that the LHIN does. We have heard that from other deputants in other locations.

Ms. Marion Quigley: I’m sure. It is difficult to manage.

Mrs. Christine Elliott: Yes. Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas?

M^{me} France Gélinas: Thank you for coming. If you think province-wide, there are areas of the province where, historically, mental health services have been better funded. I will give you the example of Ottawa and eastern Ontario. If you look at the money that goes into that area for mental health, it is way higher than what we get in the north.

How do we reconcile the fact that we’re now planning solely for the northeast? The northeast has been historically underfunded for mental health, but yet we’re now stuck planning within this. How do you reconcile this in the wonderful step forward that you want to take?

Ms. Marion Quigley: I think you have to show what the evidence is to have the new programs and the funding in the northeast. It’s just working on developing a mental health and addictions strategy in our community and working with the regional addictions mental health committee that the LHIN has set up to look at: Where are the gaps in service?

I think one of the things that we’ve really benefited from is that the LHIN has brought forward other examples of programs and services that are happening in other parts of the province. We’ve done the same. An example is the crisis program. So I think it’s just continuing to move forward and look at: Where are the gaps and where is the funding that’s needed?

M^{me} France Gélinas: Would you say that because we have a LHIN, because we now are collecting data and planning for filling up those gaps, we are in a better position to advocate for a better balance between the different regions of the province?

Ms. Marion Quigley: Definitely. I think that we look at population base, but we also look at need. The biggest thing that I see is that they are listening to what people who have lived experience need and want in their communities.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for coming. I’m very interested in your Crisis System Navigator pilot project that you’ve outlined in your annual report. How is the LHIN involved in that, or were they involved?

Ms. Marion Quigley: The LHIN brought organizations together in the beginning and said, “The crisis program is not working. You need to fix it.” So they gave the problem back to us, as community providers. We brought together all of the players. The police, as Louise mentioned, were a great partner because they were the ones who were really frustrated with the wait times.

We looked at where the needs were. We developed a community crisis steering committee that was made up of individuals with lived experience, family members, partners within the addictions mental health system, the police and the hospital. From there, we came up with a plan.

One of the strategies was the pilot project to see—moving a program out of a hospital and moving it into the community, as you might all know, has significant challenges. First of all, when you’re sick, you go to the hospital. That’s the same with mental health. So we needed to redirect people back to the community supports where they are.

The navigator was there to give people choice. People can still go to the emergency department for crisis services, but now they have a choice. And most people are making the choice to go downtown to the crisis program, and the navigator is helping with that. And so—

The Chair (Mr. Ernie Hardeman): Thank you very much.

Ms. Marion Quigley: I gave you a booklet in your package with all the outcomes.

The Chair (Mr. Ernie Hardeman): Right on the second. Thank you very much for making your presentation. We very much appreciate it.

Ms. Marion Quigley: Thank you.

CHIEFS OF ONTARIO

The Chair (Mr. Ernie Hardeman): Our next deputation is the Chiefs of Ontario: Patrick Madahbee. He's grand chief of the Union of Ontario Indians. Thank you very much, Chief, for being here this morning. I guess it is still morning. Thank you very much for being here and taking your time to come and present to us.

You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left, we will have questions from caucuses, hopefully fairly distributed, even though sometimes we hear someone question my timekeeper next to me.

With that, thank you very much, and your 15 minutes starts right now.

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Grand Council Chief Patrick Madahbee: Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Patrick Madahbee. I'm the Grand Council Chief of the Anishinabek Nation. I also hold the health portfolio with the Chiefs of Ontario, and it's in that capacity, as the portfolio lead, that I'm here today to present to you.

To provide some context to my remarks today, I will first provide you with some brief background on the Chiefs of Ontario organization. The Chiefs of Ontario is the coordinating body for 133 First Nation communities located within the boundaries of the province of Ontario. Its primary purpose is to enable First Nations political leadership to discuss regional, provincial and national priorities affecting First Nations people in Ontario and to provide a unified voice on these matters. Within this system, the chiefs and assembly have mandated the Ontario Chiefs' Committee on Health to monitor and oversee issues affecting First Nations in Ontario with respect to health policy, planning and delivery.

However, in all cases, the ultimate rights-holders are the First Nation governments and citizens, as the treaty signatories. An example of this is the treaty approaches to health that Grand Council Treaty 3 and Nishnawbe-Aski are pursuing with the federal and provincial governments, which have resulted in direct meetings with the minister.

This presentation represents the First Nations in Ontario regional response as part of the review of the Local Health System Integration Act and is without prejudice to the submissions which may be provided by individual First Nations or First Nations provincial and territorial organizations in relation to the review of the Local Health System Integration Act.

I first want to discuss the general First Nation position towards the Local Health System Integration Act. When this act was first introduced, the First Nations in Ontario

immediately expressed concern that it was developed unilaterally and without meaningful involvement of the First Nations. The bottom line is, we were not consulted on this legislation. Unfortunately, the way the act was developed and the lack of consultation with First Nations immediately put First Nations and the provincial government on the wrong path.

The 133 First Nations in Ontario are part of the Anishinabek, Mushkegowuk, Onkwehonwe and Lenape nations. Ontario was created through the formalization of treaties between indigenous and crown governments. These treaties and the trust-like relationship that evolved have created a unique relationship between indigenous nations and governments. As a result, the First Nations of this land are not simply another stakeholder or special interest group. We have unique collective rights that were recognized and affirmed in section 35 of the Canadian Constitution of 1982. By unilaterally developing and imposing the LHSIA on the First Nations in Ontario, the provincial government has failed to meet its legal duty to consult First Nations. The duty to consult has been re-affirmed in numerous Supreme Court of Canada decisions, yet successive governments continue to neglect what is a clear legal obligation.

The preamble in the LHSIA states:

"The people of Ontario and their government ... recognize the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities."

This is a nice-sounding statement; however, it is meaningless, as we have no real role in health planning for our communities under the LHSIA and the local health integration network structure. The First Nations in Ontario did try to improve the LHSIA once it was introduced, through submissions in response to a request for feedback on proposed draft regulations, specifically draft regulations pertaining to subsections 14(2) and 16(4) of the LHSIA. The recommendations that the First Nations proposed with regard to these draft regulations were not responded to. In fact, these regulations have never been enacted to date.

We've tried to work with what we believe to be flawed legislation. The LHSIA does not recognize the jurisdiction and status of First Nation governments, and the current structure of the local health integration network system provides no accountability back to First Nation governments. As things stand, the province appoints representatives to the LHIN's board. It's our protocol at First Nation governments to determine how they want to be represented and who will represent them. We believe in accountability to our citizens. The current structure established by the LHSIA does not provide this, and we have found that this conversation is a one-way street only. We get directives and instructions on how things will work and what has been decided. This is unacceptable and all too often does not align with the challenges and needs in our communities.

Sure, there may be a few pockets where our LHIN's board and the local First Nations communities have good

working relationships. There are good people working in the system. We have an example down in the Curve Lake area, where things seem to be working quite well because the First Nations are being listened to very well there. But even in situations where a good working relationship exists, there remains the problem of a one-way conversation and the lack of a real role for First Nations in health planning for their citizens.

It's not enough for the LHSIA to state that our role is recognized. This means nothing if it's just an empty statement. Section 16 of the LHSIA mandates every LHIN to engage the aboriginal and First Nations health planning entity in their geographic region; then it leaves it up to the LHIN to determine and define the entity. The 2011 draft regulation that attempted to define such an entity purported to create aboriginal/First Nation health planning entities through committees appointed by each LHIN and whose members were deemed to represent the diversity of aboriginal and First Nations peoples and communities in the geographic area of the network.

From a First Nations perspective, this proposed regulation has many flaws, including that the province, through the LHINs, would create committees and unilaterally determine who it felt was representative of the aboriginal/First Nations people and communities. It's our view that such committees would have no accountability to First Nation governments and would simply be a construct of the LHIN created to comply with the requirement to engage the First Nations/aboriginal population.

A draft regulation was also proposed to implement the section of the act that mandates the creation of an aboriginal and First Nations health council. From the outset, First Nations have made it clear that a First Nations-specific council or table is required to meet with the minister to share information and develop health plans that will prove effective for our communities and our population. We do not need to reinvent the wheel here. First Nations already have mechanisms and structures in place that can easily function as a First Nations health council.

The First Nations in Ontario insist on a "First Nations"-specific council. We are not aboriginal; we are First Nations, the indigenous peoples of this land. "Aboriginal" is a catch-all term used by governments in reference to First Nation, Métis and Inuit.

I just want to comment here. I was directly involved in the Constitution patriation in 1982. At that time, the term "aboriginal" was used because they were looking for—we said things at that time: "How are we going to phrase ourselves in this Constitution? We're not native—that's a generic term." We even found the term "aboriginal" offensive because we're original, we're not aboriginal. That's like saying "normal" and "abnormal." An elderly lady from Saskatchewan said that the preamble of the Canadian Constitution says that the First Nations in Canada were the English and French. She said, "Don't these people know that we were the first nations in this

land?" That's why you started seeing people start to use the terminology of "First Nations."

We are Anishinabek, Mushkegowuk, Onkwehonwe and Lenape. We have a distinct name for our people. This generic term is insulting. There are three distinct groups with diverse and unique needs, priorities and legal status. Continually lumping us together is wrong and ineffective.

Chair and members of this committee, the bottom line here is that the LHSIA is flawed legislation. The provincial government failed to meet their legal duty to consult with indigenous nations in this province before introducing this legislation, and then they passed it anyway, despite our objections and repeated requests to meet and discuss how things could be done more effectively in a manner that respects our aboriginal treaty rights. As I pointed out earlier, specific regulations were developed that were never enacted in respect of First Nations and the aboriginal people in Ontario. We believe that there is some recognition in governments that there are sections of the act that must be amended in order for them to work and be more acceptable to the people they will impact.

Again, the bottom line is that the LHSIA does not provide the LHINs with the necessary measures and structures to make good decisions about First Nations health. There are ad hoc arrangements that have been established between a few LHINs and the neighbouring First Nations that hold promise and can possibly be used as models to implement in other areas of the province. I suggest that First Nations and the Ministry of Health and Long-Term Care meet to identify potential good practices that exist and to consider using them more broadly. The fact of the matter is that the majority of First Nations have no real voice in the health planning within their LHINs, and this needs to change.

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The First Nations in Ontario believe that this review of the LHSIA provides a good opportunity for the provincial government to engage in a dialogue with us about what needs to be changed and what measures will result in improved health services and health outcomes for our people. Continuing to impose unilaterally developed strategies on First Nations will not work. One only has to look at the federal government's track record with First Nations, which shows that what they think is best for us hasn't worked. So the province should not be copying that failure. First Nations must be full partners in health planning and decision-making in order to achieve the positive outcomes that all parties are seeking.

Mr. Chair and members of the committee, thank you for the opportunity to present to you today. The Chiefs of Ontario has also provided a written submission on these matters, and I encourage you to review it and give it serious consideration. Meegwetich and thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have just under four minutes, so the questions will come from the third party. Mr. Mantha.

Mr. Michael Mantha: One of the questions that I have is in regard to what I've been hearing when I'm going into many of the First Nation communities: that it's hard for them to build their capacity; it's hard for them to retain their capacity; it's hard for them to provide the services that they absolutely need within their community. From your point of view, what are the most challenging reasons why that is happening?

Grand Council Chief Patrick Madahbee: There are two things, in my opinion. First of all, not having the control: When you're totally being dictated to on how things should operate and you don't have a say in what goes on, it causes problems. Then, there's the issue of resourcing. We're always asked to do a thousand-dollar job with about \$200.

I'm going to ask Tony and Bernadette to chime in here if they want to add anything. They work more on the front line of this issue than I do.

Mr. Tony Jocko: One fundamental problem that exists is that unless you have a contribution or financial relationship with the LHINs, you cannot access funding. Many of our First Nation communities do not have that arrangement in place.

The very population statistics that have been utilized by the LHINs, despite our assertions to the opposite, come from census Canada. Many of our people do not partake in the census. We have lobbied and informed the local LHINs that they should be using the INAC, or the new misnomer, for the Indian registration population. The federal government has those accurate statistics for all our First Nations, but the LHINs continue to utilize the flawed, inappropriate population stats. When it comes to funding formularies, they determine that First Nations in each LHIN comprise a certain percentage of the population. Sadly, that's often the way the funding is flowed to different interest groups, in terms of population.

Any time you have legislation where the minister has the right to amalgamate or disband and also controls the purse strings, you have a serious compromise in terms of local. Local becomes an oxymoron. It's not truly locally controlled—and we all know that that would be the best scenario. Moving the solution of any problem further away from our people has never served us well.

The political insistence—and we were encouraged by that—that there would be an advisory committee to the minister fell off the rails. It has never transpired.

These types of challenges continue to plague our people every day. When we try to have a relationship with the LHINs, the failure to consult and develop a real relationship—if we had a buffalo nickel for every time we were asked by a provincial body, "How do we engage First Nations?" They fail miserably at that. They don't know how to engage. Given the MOH's funding cycle, the decisions are often made internally without any true consultation, and then it's rolled out and we're told, "This is what we're going to do for you," or there's no money left.

There are some fundamental flaws in the whole process, and this is what really has us on the outside looking in.

We've heard for years that an Ontarian is an Ontarian is an Ontarian. It seems to be that way except when it comes to Ontario's First Nations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this morning. We very much appreciate your coming in and speaking to us.

That does conclude the time for your presentation.

Mr. Tony Jocko: Thank you.

CAPREOL LONG-TERM AND SUPPORTIVE HOUSING

The Chair (Mr. Ernie Hardeman): Our next presentation is the Capreol Long-Term and Supportive Housing: Tullio Ricci.

Ms. Tina Junkala: Good morning.

The Chair (Mr. Ernie Hardeman): —and Tina Junkala.

Ms. Tina Junkala: Thanks.

The Chair (Mr. Ernie Hardeman): The fundraising chair, and Mr. President, sir. Thank you very much for coming in. You have, as all the presenters have, 15 minutes to use as you see fit. You can use any or all of that time. If there's any time left over, 10 to 15 minutes, we'll have questions from caucuses.

Thank you very much for being here, and we look forward to your presentation.

Ms. Tina Junkala: Thank you very much for having us here. We really look forward to the opportunity to share our project with you. It's an exciting one.

I just want to take a minute to introduce our president. Tullio Ricci is a pillar in our community, in Capreol, a true visionary and a true going concern. He has really done some amazing things for us out in Capreol.

Tullio served as city councillor for the town of Capreol for 17 years, and while in politics, he consistently sought for the development of housing services in the Capreol community.

Tullio was the driving force behind the development of Capreol Non-Profit Housing phase 1 and Capreol Non-Profit Housing phase 2, which consist of 40 units for seniors, with rent-geared-to-income and affordable housing. Tullio continues to work closely with the management of these two complexes to ensure the ongoing sustained viability, and he is the president of both those boards as well.

Tullio has resided in Capreol for 58 years and, for 40 years, was employed by the Canadian National Railway in various management capacities.

For 10 years, Tullio was chief of the fire prevention bureau, president of the Sudbury mutual aid firefighters' association, and also deputy fire chief. For 12 years, Tullio served our community as fire chief and coordinator of the first-response team. Tullio was involved in the rewriting of the Ontario fire code and the Ontario building code, which is still in effect today.

Tullio has been retired for the past 20 years from the railway but is still very much involved in our community.

Tullio served with the Lions Club, Knights of Columbus, Red Cross, Heart and Stroke Foundation, Canadian Cancer Foundation and many others.

It is with great pride I present to you Tullio Ricci.

The Chair (Mr. Ernie Hardeman): Thank you very much.

Mr. Tullio Ricci: Thank you very much, Mr. Chairman.

The Chair (Mr. Ernie Hardeman): It will start itself.

Mr. Tullio Ricci: Oh, that is off? Okay, thank you very much. You'll have to put up with me, because these are new glasses and I forgot the reading glasses at home. You know me, France.

M^{me} France Gélinas: Yes, I do.

Mr. Tullio Ricci: I don't know where these come from, but I'm trying to read it to you.

As Tina said, I've been involved with the community, but that's only part of it. There's a lot more than that on the labour front. I was also with the CLC.

LHINs: an opportunity for supportive housing and social housing.

The local health integration networks have a history of working with supportive housing. The recognition that many tenants not living in supportive housing need support to maintain their housing has led some LHIN agencies to begin new partnerships with other housing providers.

Since their creation in 2006, Ontario's 14 local health integration networks have assumed the Ministry of Health and Long-Term Care's role in funding community-based support services.

In addition to their role in the supportive housing sector, some LHINs have begun to fund support services for tenants living in non-supportive for-profit housing. This is a new and promising frontier.

Generally, LHINs remain tentative about getting involved in non-supportive housing, which falls outside the narrow definition of health policy.

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Non-profit housing providers are increasingly concerned about the number of tenants with unmet support needs. The results of the absence of support have frequently reached the front page, from fires to hoarding to poor housekeeping to terrible outcomes for vulnerable seniors unable to live alone in the absence of assistance.

At present, there are many cases of seniors' housing providers, such as Capreol, served by multiple community care access centre case managers—responsible for referrals to support services—and various community agencies, that continue to have unsupported tenants with unidentified needs. This is because access to support services is largely driven by referral instead of outreach. This model clearly does not work for seniors who lack sufficient social supports to make the connections happen.

LHINs should be partners with assisted housing corporations and encourage new development to address

health challenges in a comprehensive way. Instead of waiting for individuals to arrive in a hospital for costly emergency procedures, the LHIN has the opportunity to deliver preventive services efficiently to our disabled population, who require support.

On the northeast side of our city, the need for supportive housing is very high on the radar, especially with seniors facing daily challenges with mental health and addiction issues that are undetected. It ultimately places a substantial burden on the health system. Mental health professionals are expecting that mental health will double in the next decade.

We, as housing providers, look forward to working with the LHIN to address many challenges to our people in need in their daily chores, and there are many. I understand that the LHIN has started to fund outreach-based services directly, to reach seniors in non-profit housing—for example, Ottawa Community Housing.

As the president of the Capreol non-profit housing corporation, representing seniors on RGI and affordable housing, I strongly recommend the committee to encourage the LHIN to expand their role and increase funding required for this agency to continue the work they are doing with the seniors population.

As president of Capreol Long-Term and Supportive Housing, which I have created in the hopes of bringing forward these facilities in our community, for the people in the northeast of the city of Greater Sudbury, which has a population of 34,222—this population covers Capreol, Ironside, Wahnapiatae First Nation, Skead, Garson, Hanmer, Val Thérèse and Post Creek.

The board consists of volunteers, who are professionals in their fields, such as doctors, pharmacists, registered nurses, business owners, financial managers, advisers and domestic engineers. We are, as a board, well aware of what the LHIN is doing in the region. Therefore, we are pleased with the work and results accomplished by the local health integration network. This agency is very essential to this region.

We are also aware of the many negative complaints toward this agency by some members of the public in general. Of the complaints that have been filed, none have been proven to have neglected any health policy sent out by the minister's office.

We must also focus on human error. We are human, and as a species of humanity, we make mistakes. Therefore, as we move ahead, we learn from these mistakes and find the proper solution, to improve with other agencies providing health care for our seniors.

The LHIN is an integral part of northern Ontario. People in the north are able to connect one-on-one and discuss many problems that arise on a daily basis, either personally or with community development. This makes this agency more connected to the needs of the population. I must stress to the committee the LHIN is doing all of that and more.

Personally, I have nothing but praise for this agency. I have had the privilege to work with the Sudbury-Manitoulin health council, with Ms. Paquette, and during

that time, we also developed a document called *The Next 10 Years*. This document became an important, valuable document when the commission was created by Mr. Harris's government and led by Mr. George Lund, commissioner, to amalgamate the three hospitals into one.

The document called for an increase in hospital beds, but only 328 were built. Therefore, much of the problem does not lay with the LHIN, but rather with the government—the blue book revolution leader, Mr. Harris. As well, the Ministry of Health's staff estimated the cost of amalgamation to be a substantial amount of money and not what was presented to the public.

The LHIN has also been accused of not responding to the public in a timely fashion to the public's complaints. Maybe this is a lack of staff in the office, or maybe a lack of funding to operate this agency. Whatever it is, we must find the funding to make this agency operational.

There is \$110 million at the Northern Ontario Heritage Fund under the Ministry of Northern Development and Mines' file. Perhaps some of this money should be shared with the LHIN for community development so that citizens with physical disabilities not ready to be institutionalized in the long term could be housed in supportive housing complexes at much less cost to the health budget.

Many MPPs from the opposition are demanding to scrap this agency. Maybe they are not aware what kind of work this agency is doing, especially trying to please everyone in the large geographical area of the north, in some cases with no roads for transportation for many isolated pockets of villages in the region. As the president of Capreol Non-Profit Housing Corp., representing over 100 seniors with multiple physical disabilities, unable to function properly, I would hate to see the LHIN move out of our region.

I have been involved with seniors and health providers in the community for the past 33 years. I was the one who organized the first-response team as an instructor with St. John Ambulance first aid. I had the opportunity to instruct my volunteer firefighters on a weekly basis. Also, we were the first community in Greater Sudbury to purchase a defibrillator at the cost of \$6,529.43. We, as volunteers, raised that money to purchase that equipment for the community. The Royal Canadian Legion Ontario Provincial Command also purchased one for us with a cardiovascular tape reading for the doctor on duty at ER.

As a fire chief and coordinator of first response, I worked very closely with the community services agency in reducing the response time for land ambulance from one hour and 45 minutes to 19 minutes and brought air ambulance service to our community, which is still in order today.

As we move forward, we'd like to see that the LHIN remain in the north to look after the vast area that they are covering and bring health care closer to the people who need it in our remote towns and villages.

At the present time, our board is working with the LHIN to erect 44 units of supportive housing projects to accommodate our frail, disabled seniors who are not

ready to be admitted to long-term care but need assistance. Our seniors need three nutritious meals a day on a daily basis to keep them out of the hospital and out of the expensive institutions. We need the LHIN in the north to work with us and bring health care costs down.

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We are aware that the cost in a hospital is about \$750 daily. We are also aware that private long-term-care institutions range from \$350 to \$500 daily. Non-profit organizations are able to give the same care to seniors at much cheaper costs to the system and the seniors are able to stay at home in their communities where they raised their families.

I personally have been involved with the LHIN and CCAC for many years. At no time have these organizations turned me down. They are always able to meet with me on my time to discuss situations that arise from time to time and come up with solutions to give better service to the community.

As president of Capreol Long-Term and Supportive Housing, I would like to recommend to the committee that the LHIN have access to funding from the Northern Ontario Heritage Fund to help small communities in the north to build new facilities for our disabled seniors who are no longer able to stay at home and are not ready to be admitted to long-term-care facilities. I trust that this committee will make proper recommendations on the legislation and keep the LHIN in the north.

I also feel that the LHIN should be operating in Sudbury, which is the centre of the north, with the school of medicine at the university and the research department at Health Sciences North. Sudbury is also central to major cities like Sault Ste. Marie, Timmins and North Bay.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have expired our time by a minute already. Thank you very much for your presentation. I can assure you that the committee will read everything that was in the presentation in their review.

Mr. Tullio Ricci: Thank you. Sorry about my voice. I was sick for a week.

COMMUNITY COUNSELLING CENTRE OF NIPISSING

The Chair (Mr. Ernie Hardeman): Our next presenter is the Community Counselling Centre of Nipissing: Alan McQuarrie, executive director. Thank you very much for being here this morning to make a presentation. We appreciate you putting in your time. You will have 15 minutes to make your presentation. If there's any time left for questioning, we will have questions from caucuses. With that, thank you very much.

Mr. Alan McQuarrie: Thank you. Mr. Hardeman, Chair, committee members, I'm Alan McQuarrie, the executive director of the Community Counselling Centre of Nipissing and co-chair of the Nipissing mental health and addictions system table.

I want to start by thanking you for the opportunity to speak to your review of the Local Health System Integration Act and the regulations made under it.

I've been an executive director for two organizations receiving funding for health care since 2003. When I first began my work under the guidance of the local district health councils and the Ministry of Health, I was working in a system that was characterized by divisions and a lack of communication. As a service system, there was very little innovation. Instead, we sought resources for our siloed agencies to do more of what we were already doing. Due to the reality of life in northern Ontario and the vast geography here, we rarely met our program supervisors from the Ministry of Health, and when programs were rolled out from Toronto, they tended to be a one-size-fits-all format. New initiatives rarely took into account the demographics and socio-economic realities of the north.

The few projects of integration that I was involved in at the time were usually because we knew our fellow service providers as neighbours, a function of small-town northern life and not really any kind of organized integration. When the North East Local Health Integration Network arrived, we finally felt that we had a regional presence for the planning and funding of health care. The North East LHIN was the voice of northerners, identifying northern needs and priorities.

The arrival of the LHIN was the first time in my career that serious thought was put into identifying the unique health care needs of our northern population. Through numerous consultations with stakeholders from all corners of our region, the North East LHIN put in place four priorities for health care:

- increasing primary care coordination;
- enhancing care coordination and transitions to enhance patient experience;
- targeting the needs of culturally diverse population groups; and
- making mental health and substance abuse services more accessible.

As a health care provider in the north in the community mental health and addictions sector, my work falls under the fourth priority of the North East LHIN. Since the arrival of the LHIN, we now have a local program consultant who meets with us face to face. We now have a process for our local mental health and addictions system table to communicate our realities and to plan together to improve access to health care.

In Nipissing, we have a network of nine community-based agencies working to provide housing, peer support, counselling, addictions treatment, and community integration. Guided by the North East Local Health Integration Network, these agencies touch the lives of thousands of people in the district of Nipissing alone.

Keeping people healthy starts in the community, and community organizations are strategically placed to connect with people before they need the hospital. However, a frequent stereotype of community, provincially funded programs is that there are too many; that these

organizations don't work well together; that these organizations have administrations that are expensive and redundant; and that diversity in the social services field is synonymous with inefficiency, duplication and too many wrong doors or difficult access. The truth, however, is very different. The innovations of our community service partners are not always well known; however, they are serving our populations in new and creative ways, increasing the health of our citizens like never before. Under the guidance of the North East LHIN, our system table now has a process to innovate, to plan, to coordinate, and to implement new and exciting health supports for our communities.

I'd like to share some of the accomplishments of our mental health and addictions system in Nipissing with you this morning.

In 2012, People for Equal Partnership, a local agency, began a unique program in conjunction with the North Bay Regional Health Centre, putting a peer support worker in the hospital emergency room. Now people with a mental illness have an advocate and an ally when they arrive at the hospital. Often, the peer advocate can improve the quality of care and redirect people to community resources instead of repeat, expensive hospital visits.

The Common Referral program is a joint initiative of many agencies that coordinates addictions and mental health referrals each month. These are triaged and in many cases are fast-tracked to community services, where they receive support outside the emergency room.

The community counselling centre that I represent has implemented a walk-in clinic since mid-September, and statistics are showing that 18% of the 76 respondents completing the surveys would have used the hospital or the doctor if the walk-in was not available. A walk-in clinic is a creative way to eliminate barriers to access such as wait-lists.

The Canadian Mental Health Association in Nipissing, Nipissing Mental Health Housing and Support Services, People for Equal Partnership, and the North Bay Regional Health Centre have been attending the gateway hub community mobilization meetings, which provide quick intervention and wraparound services to high-risk clients, thereby reducing the need to attend the ER.

CMHA Nipissing and the North Bay Regional Health Centre work together to provide housing and support to 20 people who now have a supported community destination when they leave the wards of the hospital.

The North Bay Recovery Home continues to provide an ongoing aftercare program that supports the continuum of care. They also follow the No Wrong Door procedure that enables cross-referrals for the overall health and wellness of heavy users and recurring users of the addictions and mental health system. The recovery home is co-chairing the North Bay and Area Drug Strategy Committee and is developing a local protocol for the return of used fentanyl patches—you may have heard that on CBC Radio; there was an interview recently—thereby reducing the medical emergencies that might arise from misuse.

The Alliance Centre participated with two other non-health-funded agencies during Addictions Awareness Week to present community education in the area of trauma and mental health and addictions. The events were well attended and resulted in increased awareness of community services.

This year, North Bay Regional hospital hosted a PhotoVoice event to promote mental health and to highlight community mental health services as a diversion from the ER.

Nipissing Mental Health Housing and Support Services has a shared memorandum of understanding with the crisis intervention services of the North Bay Police Service and the OPP, which allows for shared, facilitated interventions and consistent follow-up to prevent recurrent presentations to the hospital ER.

Nipissing Mental Health has established a respite unit as part of its Percy Place residence, offering clients brief respite from their current living arrangements, who may be temporarily without housing supports. Supports accompany the client to ensure successful tenancy in the unit.

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Teaming up with West Nipissing General Hospital's emergency department, the Alliance Centre is currently looking at strategies to reduce repeat ER visits for mental health and addictions clients. To do this, they have implemented a community wellness program and are participating in several committees, including the Nipissing drug strategy committee, the suicide prevention task force and the Common Referral table. They're also partnering with several agencies to provide community education, awareness and promotion in the areas of trauma, mental health, suicide prevention and addictions.

416 Lakeshore is a partnership of the Canadian Mental Health Association and the North Bay Regional hospital. The 416 Lakeshore property houses 20 people who do not have anywhere else to live. Many of these people are dealing with mental health issues and addictions, social isolation and traumatic life events, and have difficulty accessing many of the supports that most of us take for granted. The 416 Lakeshore property is more than housing: It provides a community of care and support, and it also provides people with the means to live independently and to achieve their goals.

This is just a list of some of the many joint interventions that are currently or recently were in the works. A closer look at the community mental health and addictions system shows a network or an ecosystem of dynamic, creative agencies working together to find a new and better way to improve the health of our citizens.

Through the support of the North East LHIN, we have found ways to improve access to mental health and addictions through creativity, innovation and integration of our shared resources. We're grateful to the LHIN for guiding and supporting local initiatives that are tailored to the needs of our local populations. By fostering strong community health care programs, we are improving ac-

cess to health care in the clinical areas of addictions and mental health.

Speaking as a table chair, the North East LHIN is our LHIN; but speaking as a citizen and a patient, the North East LHIN is my LHIN. It's a voice for northerners for better health care. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about two minutes for each party, starting with the government side. Mr. Colle.

Mr. Mike Colle: Thank you very much. I'm most interested in this 416 Lakeshore project. This seems to be an ongoing theme across the province. I know even in my own riding in Toronto, I've got the local police superintendent saying that more and more police time is being used dealing with people with addictions and mental health challenges. They just don't know where to take people for help, so they spend hours in hospital waiting rooms, ERs, so it's clogging up the ERs, plus it's clogging up police time. How did you ever get this up and running?

Mr. Alan McQuarrie: The 416 Lakeshore project was really a project of the Canadian Mental Health Association. It's difficult for me to talk at length about what was the start of that, but I know they were approached with some housing dollars, and then they approached our system table, saying, "Look, we can't make this work on our own. We can provide a building, we've got infrastructure, but we're going to need some support to make this work for people, because they're being discharged into the community from the hospital, let's say, and the chances of things breaking down are fairly high."

Through collaboration of the local system partners, we were able to find the resources to staff a person during the day at the 416 Lakeshore site. It's just providing that little bit of support that people need to be able to function effectively in the community. We believe it has really reduced some of the pressure on the hospital system.

Something you may be interested in is the gateway hub model of community policing that is coming to North Bay. I just mention it briefly here. Some of our system providers are involved in that. It's an initiative that provides wraparound services, with the police involved, and we identify high-risk people and provide services to them.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming in with your presentation. I have a couple of questions. How does the LHIN coordinate the program that you mentioned here on the first page—a program consultant who meets face to face?

Mr. Alan McQuarrie: Yes. Our program consultant with the North East LHIN meets with our system table at our monthly meetings. We also connect with her regarding our MSAA, our service agreements. We have much more of a relationship now with our health funder than we ever had in the past.

Mrs. Jane McKenna: But how did that come to fruition? How did that program come to fruition?

Mr. Alan McQuarrie: I believe the LHINs set that up as part of their process, the renewal of funding. At the system table—the LHINs have the resources now to attend the system table meetings on a monthly basis.

Mrs. Jane McKenna: We hear over and over again that people are exhausted from panels and round tables and discussions. What is actually implemented after all of these discussions that you have?

Mr. Alan McQuarrie: I could probably point to most of the innovations that I've read in my paper today as coming from discussions of the system table. The LHIN being part of that has helped us to move that forward.

The Chair (Mr. Ernie Hardeman): Thank you very much. The third party: Mr. Mantha.

Mr. Michael Mantha: A question with regard to your community counselling centre that started up the walk-in clinic: Can you just give me a little bit of the background on how that got generated and how it's actually operating? I see some of the benefits here, but can you elaborate on that?

Mr. Alan McQuarrie: We became aware of a pilot project in Thunder Bay. It was identified in a document on excellence in health care that I believe came from the LHINs, or at least the Ministry of Health. We contacted the Thunder Bay agency. It's a partnership between children's mental health and adult mental health. Through discussions with our provincial association, Family Service Ontario, we started a pilot project of our walk-in program. We've allocated existing funding dollars to service our walk-in clinic, and, as a multiservice agency, we're able to pretty well see whoever comes in off the street.

Mr. Michael Mantha: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated, you taking the time to come and talk to us.

Mr. Alan McQuarrie: Thank you.

NORTHERN ONTARIO SCHOOL OF MEDICINE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Northern Ontario School of Medicine: Roger Strasser, the CEO. Thank you very much for your attendance this morning to help us out with our information-gathering sessions. You will have 15 minutes to make a presentation. You can use any or all of that time with your presentation. If there is sufficient time left, we'll have questions from caucuses. The 15 minutes are yours, sir.

Dr. Roger Strasser: Thank you very much for the opportunity to come and meet with you this morning and talk about my observations and experience in relation to the Local Health System Integration Act. As you said, I'm from the Northern Ontario School of Medicine. My name is Roger Strasser. I'm the dean and, as you said, the CEO of the school. The remarks I'm going to make are

really about the whole of northern Ontario. I understand that you're also spending some time in Thunder Bay. It just worked, from my calendar perspective, to meet with you here rather than in Thunder Bay.

What I'm going to do is talk about the Northern Ontario School of Medicine and give you a sense of the perspective that I bring in looking at the local health integration networks, talk about the concept of the LHIN and then talk about the experience in the north of the LHINs that we have in the north.

The Northern Ontario School of Medicine came into existence as the result of a widespread community movement which said that if we're ever going to turn around the shortage of doctors and other health professionals in northern Ontario, if we're ever going to improve the health status of the people of northern Ontario, we need to have our own stand-alone northern Ontario school of medicine. That was the background. I imagine that some of you were even involved in this movement back in 2000-01. That was the background to the Ontario government deciding to establish the Northern Ontario School of Medicine.

The school has a social accountability mandate. That's a commitment to be responsive to the needs of the people and the communities of northern Ontario, with a focus on improving the health of the people of northern Ontario.

The school serves as the faculty of medicine of Laurentian University here in Sudbury and of Lakehead University in Thunder Bay. We see the whole of northern Ontario as a campus of the Northern Ontario School of Medicine.

We've developed what we call distributed community-engaged learning as our distinctive model of medical education and health research for the Northern Ontario School of Medicine. There are three key elements of distributed community-engaged learning: distributed—that is, the teaching, learning, research and academic activities occur in multiple locations. We have over 70 sites across northern Ontario where our students, residents and faculty members may be involved. In order to have this kind of distribution, we place heavy reliance on electronic communications to facilitate this distributed learning. We have an extensive digital library service, which means that our learners, faculty members and community members have the same access to educational resources wherever they are, if they're on the Internet, as if they were in the big city, like in a teaching hospital.

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The third component is community engagement. This is interdependent partnerships between the school and the community, so working in close collaboration with the communities of northern Ontario. That's the rural communities, the large population centres, as well as the populations of special interest: the aboriginal people and communities and the francophone people and communities.

So that's the Northern Ontario School of Medicine and how we go about things. You have some handouts and the opportunity for you to look at those closely. I think it

is fair to say that already the school has surpassed its expectations. We had the official opening in 2005 and the first graduation from the MD program in 2009, so we've had five groups graduate. We do have our own graduates now providing health care in northern Ontario, so the outcomes are certainly very positive. First of all, our graduates compare favourably with graduates of other medical schools in terms of matching to residency programs and in terms of their academic performance in the Medical Council of Canada. But what's probably of most importance to people in northern Ontario is that 62% of our graduates have chosen family medicine, mostly rural family medicine, as their career pathway. That's double the national average for Canada. Thirty-three per cent have chosen other general specialties, the kind of specialists we need in northern Ontario—and just 5% subspecialties like dermatology, plastic surgery and radiation oncology. So there are signs of success for the school.

We also undertook a socio-economic impact study of the school some years ago now, and we showed that the school has had a positive impact in terms of the economy of northern Ontario. The year that was studied, the budget—taxpayers' money—was \$37 million; the level of new economic activity in that year was between \$67 and \$82 million, so more than a two-for-one multiplier effect. There was economic growth—that's new jobs and economic development—and new job categories that we wouldn't have in northern Ontario without a Northern Ontario School of Medicine.

Probably more interesting was the social impact. Yes, the universities reported improvement in retention and recruitment of faculty members and students. Yes, the health services reported improvement in recruitment and retention of health care providers. But what was really interesting was the communities themselves. This research was done in 2009, just after the global financial crisis. As you know, the northern Ontario region is very much a resource-based economy, so things were looking pretty bleak for the communities in northern Ontario in 2009, and yet the people who were interviewed as part of this research actually were optimistic about the future. They linked that to the Northern Ontario School of Medicine. It wasn't just about more doctors and access to health care; there was a sense of empowerment. These people had been part of that community movement, and they had been involved in advocating for having a Northern Ontario School of Medicine. So there's a sense of, "Well, if we can do a successful medicine school, we can do anything." I think it is fair to say that now Lakehead University has a law school, Laurentian University has an architecture school, and the idea of those sorts of professional schools at those universities would not really have gained much traction without the success of the Northern Ontario School of Medicine to point to.

So I've given you a snapshot of the Northern Ontario School of Medicine and the perspective that I bring now to look at the idea of having local health integration networks in Ontario, and I must say I think it's a good

idea. I think the basic principle of developing and implementing health services through collaborative processes involving all of the key players is a very positive way to go, as compared with the straight regional health authority model, which is really a central-control model. Generally speaking—and in one way or another I've seen many other jurisdictions, not only in this country, but other countries as well—the sense in the small communities is that they are the losers when you have a regional health authority type of model. So I think it's a good idea. To be successful, it's essential to strike the right balance between the local needs and advocating for health care that meets local needs and in the communities of the region with the province-wide priorities and initiatives. That's a constant tension, I think, for the local health integration network and for the idea of local health integration networks. I think that, in the way that that they've been set up in Ontario, there are some limitations, in particular that there are aspects of service and health care that are not included: in particular, public health, and also the whole issue of the way in which physicians are funded to deliver health services.

That's a snapshot of observations about the concept of local health integration networks.

The experience of the LHINs here in northern Ontario: I must say, when the decision was made to have a North West LHIN and a North East LHIN, I said to anyone who listened, "Isn't government funny? They set up one Northern Ontario School of Medicine for the whole of northern Ontario at a time when there was one north region office for the Ministry of Health and Long-Term Care, and now there are two local health integration networks."

The approach that we took with the Northern Ontario School of Medicine was to say that we are keen and, in fact, very committed to working in collaboration with the local health integration networks, and that our preference is to work with them together, rather than separately. We have collaboration agreements with both the North West LHIN and the North East LHIN; we meet on a regular basis with a joint relations committee, where we keep each other up to date with what we're doing. We look for opportunities to collaborate with the two LHINs and the school of medicine together.

It took some years for the LHINs to get on their feet; I must say that it took some years for the Northern Ontario School of Medicine, as an organization, to get on its feet, so I can see that that would take a while. Now that the LHINs are well established, I think there are some real opportunities for working together.

One of the issues, though, is that it's important that the LHINs really have supportive, collaborative relationships with all of the health service agencies across the north. At times I think that there are some real tensions, particularly between the regional hospitals and the LHINs. To some extent, that's built into the system—you might say as a floor in the system, because, with the requirements of the Canada Health Act, hospitals have to accept all comers, and other agencies in the system don't have that

same requirement. Then we have this situation of people getting stuck in hospital and not being able to move on to other forms of care if they're not able to go home—the so-called alternate-level-of-care or ALC issue.

But I do see some real opportunities, as I mentioned, for the Northern Ontario School of Medicine. Community engagement is really central to everything that we do, and I see some potential for the LHINs and the school of medicine to work more closely together in terms of community engagement and developing innovative approaches to health care delivery, really improving health care and, ultimately, the health status of people in northern Ontario.

Just to wrap up my brief presentation: I've introduced you to the Northern Ontario School of Medicine, I've talked about the concept of local health integration networks, and then given some observations about the implementation of local health integration networks here in northern Ontario—that's the North West and the North East.

In conclusion, I would say that I see the LHINs as a positive initiative with great potential for further integration of health service development and delivery, including through collaboration with the Northern Ontario School of Medicine. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We just have time for one party's questioning. Mr. Dhillon?

Mr. Vic Dhillon: Thank you very much for your presentation. As an alumnus of Lakehead University, I'm very happy to see that finally the school of medicine is up and running. I know that when I graduated, it was a thing that the university executive was talking about. The town and the university were very excited.

I just wanted to know: What percentage of students who graduate go to serve underserved communities in northern Ontario?

Dr. Roger Strasser: It's too early for us to give you hard and fast figures on that. As I said, we've only had five groups graduate from the MD program. After the MD, they then move into residency, and residency is a minimum of two years for family medicine—often three years—so it's early days yet to be able to have enough experience to give you numbers for that.

I can certainly give you some examples of stories. For example, in the northwest, in Dryden, there's a community that was struggling to maintain medical services, and now they're full of graduates from the Northern Ontario School of Medicine.

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Here in the northeast, the standout story is Chapleau. Chapleau went for nearly seven years without a permanent doctor. Since July 2012, they have three home-grown physicians. "Home-grown" means the three of them grew up in Chapleau. They did their MD degree with NOSM. They did their family medicine residency with us. As I say, since July 2012, they've been practising together, providing health care in Chapleau. One of

those physicians is First Nations, and she's serving her own Brunswick House First Nation.

Mr. Vic Dhillon: Thank you.

The Chair (Mr. Ernie Hardeman): No further—

Ms. Helena Jaczek: Is there still time?

The Chair (Mr. Ernie Hardeman): Ms. Jaczek, yes. We have less than two minutes left.

Ms. Helena Jaczek: You said it was a little strange that there are two LHINs in the north.

Dr. Roger Strasser: Yes.

Ms. Helena Jaczek: Would you advocate for any sort of amalgamation at this point?

Dr. Roger Strasser: Well, yes. I would advocate—and I'm talking about northern Ontario—to look at the whole of northern Ontario, I'd say the northwest and the northeast. Clearly, there are differences and distinctions between them, but they have more in common than divides them. And then, in terms of population, you have a critical mass of around 800,000, which then provides opportunities that we've managed to make the most of with the school of medicine, and I would say in terms of health service delivery the same.

The reality for living and working in the north is that most of the time, the key decision-makers like yourselves are in Toronto, and there's little attention paid to the north. So the more critical mass of collaboration that we can have across the north working together—the Northern Ontario School of Medicine was very much a made-in-northern-Ontario initiative. Encouraging local initiative across the north and networking across the north I think would be of benefit to the north and to the whole province.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate it.

NORTHERN INITIATIVE FOR SOCIAL ACTION

The Chair (Mr. Ernie Hardeman): Our next is Northern Initiative for Social Action: Shana Calixte, executive director. Thank you very much for being here this morning and sharing your time with us. You will have 15 minutes to make your presentation. You can use any or all of that time as you see fit. If there's time left over at the end of your presentation, we will have some questions from the committee.

With that, starting now, the next 15 minutes are yours.

Ms. Shana Calixte: Thank you very much. Thank you, everyone. My name is Shana Calixte, and I am currently the executive director of a mental health organization named NISA. I am pleased to be here today to talk to you briefly about our organization, the over 200 members who rely on our services, and the support we've received from the North East LHIN in this regard.

The Northern Initiative for Social Action, or NISA, as we call it, is a growing grassroots organization located here in Sudbury. We're a very unique organization with a very interesting point of view on the realities of living with mental illness.

At NISA, all of the employees within our team have lived experience with mental illness, myself included, either personally or through a family member. This uniqueness means that all of our staff members have a very special lens on mental illness and mental health and provide a very important bond with those who use our services. We've been there, and many of our members profit from sharing their stories from those who can relate.

NISA runs programs and services that focus on the recovery of the individual, a process that we describe as more of a journey rather than a destination. Our work centres in four areas: building occupational and vocational skills, providing spaces for creative engagements, one-to-one peer support, and general resources for mental health recovery.

NISA was a very small organization when I first joined four years ago. We had five staff members, about 30 active members, a small budget and one tiny location here on the grounds of the current psychiatric hospital. Over the past four years, we have grown to 35 employees; a much larger budget; two locations, soon to be merged into one larger and more spacious home; and over 200 active members. We see at least 50 people come through our doors every day looking for a space to engage with others and to develop practical and useful strategies for living within the city as people who use mental health services.

These changes have been supported and encouraged by the North East LHIN, who have been very clear that they are interested in making sure that people who use services in our city, specifically mental health services, should be heard first and foremost about changes within their care.

Over the course of the five years I have been with NISA, representatives from the North East LHIN have proven to be open to suggestions, available for discussion, and eagerly interested in hearing about the needs of those who access mental health services. When it comes to mental health care, engaging those who use the services has been one of their priorities, and they have expanded resources that support those who are most marginalized. This includes supporting an organization like ours, which sees these marginalized people every day and facilitates discussions to discover their needs and translate them into programs and services.

As a result the LHIN has supported us in providing occupational programs for members in our city. It has funded a regional, nightly, pre-crisis warm line service, which you have a brochure about there, which fields over 5,000 calls every six months. And it has fostered a collaborate relationship between mental health partners to build and staff an eight-person transitional home which has provided housing for those who would be better suited to live in the community rather than in the hospital.

Building community partnerships is important, specifically in the field of health care, which has a habit of working in silos and not necessarily communicating in

open and streamlined ways. The LHIN has not only worked to build partnerships between those working in mental health care in our city, but representatives have been available to talk directly to the service users in their spaces and on their terms. In this way, the North East LHIN has taken actions in line with some of the recommendations of the Drummond report: firstly, by improving service integration, and to produce a more efficient system by providing support that is firmly rooted in the community it serves.

The North East LHIN has clearly indicated how important it is to truly work on engagement. With diverse communities due to race and culture, rural and urban geographical areas, and various income levels, the North East LHIN has had to be accountable to many voices, working to meld the needs and concerns of all within this vast space of northeastern Ontario.

They have made a commitment to enhance community services in the mental health sector, placing trust in the work that happens on the ground and at the grassroots to make fundamental changes to our mental health system.

An example: It was a wet and miserable day when Mike O'Shea from the North East LHIN came to visit NISA to get feedback to help craft their multi-year Integrated Health Service Plan. The room was full, and more and more people kept streaming in to give their take on the needs of those living with mental illness. It was almost a two-hour discussion, where members gave frank opinions on things that were working and what they thought was not. Some words were tough and angry, but all were accepted with openness. When the plan was crafted, a very clear focus on peer support—which is the unique work that NISA does; where those who have lived experience with mental illness are employed to provide support with those with similar experiences—was present in that report. Many members still speak about that day, most specifically about how empowering it felt to be heard by and have access to those who have a hand in making direct decisions about funding. They look forward to more opportunities to engage with the LHIN in more one-on-one sessions.

In my estimation, I have found the North East LHIN to have been quite accountable to the needs of those who are direct service recipients for mental health care. Their attention to the specific needs of the geographic region, the interest in collaboration and encouraging service providers to work together and break down silos, and the attention to the service recipient—indeed, to focus on client-centred care—have all been ways, I believe, that the North East LHIN has been fundamental in the ongoing support of mental health care in northeastern Ontario. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have almost nine minutes left. We start this one with the official opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation this morning, and thank you for the great work that you're doing in the community. Many

members of this committee also served on the committee for addictions and mental health some years ago—Ms. Gélinas, Ms. Jaczek and I—and we certainly understand the importance of peer support. It really can't be stated strongly enough how important that is.

Your agency started, it looks like, in 1997.

Ms. Shana Calixte: Yes.

Mrs. Christine Elliott: So you would have been working under the old system and then transitioning into the situation with the LHINs. Can you tell us how things were before and how they've changed since the LHINs have come into existence?

Ms. Shana Calixte: I'm not quite sure I could comment on that; I've only been with the organization for four or five years. The LHIN has always been present in terms of my own experience. However, I can speak to going from a very small organization. Just to explain a little bit, we have a relationship with the local CMHA here, which actually is our flow-through funder. We don't actually have a direct relationship with the LHIN, although we've always wanted to, but we have realized over the past few years that it's important to work more collaboratively.

What I've found over the past five years I've been with NISA is that we've been able to have much more discussion, I would say, and many more people at the table to discuss how services can be improved. And because our organization has gone from a small one to a large one, we've had to really prove why that was important. We've used the relationship with CMHA in order to do that and also in order to access some more feedback from the LHIN.

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When I first started, I didn't often speak to any members within the region about our services. As we've grown, I've been able to report back how we've done, what kind of improvements we've had. I've been very well supported by having direct conversation with members of the LHIN. That's how I've seen it change in terms of the fact that I've been able to have more ready access to people who have a very important stake in how our service has changed.

Mrs. Christine Elliott: Can I just ask a follow-up?

The Chair (Mr. Ernie Hardeman): Really short.

Mrs. Christine Elliott: You mentioned that you would rather have a more direct relationship rather than being a flow-through. Can you tell us what you think you would get from that that you're not getting now?

Ms. Shana Calixte: We had wanted it, and so our understanding was that it would mean that we'd have more ability to increase our service and increase our funding. What has happened, actually, is by working in partnership with other mental health organizations, we've seen how collaboration is the best way to be supported. I would say that I'd actually rather have this kind of organization, mainly because it means we don't duplicate services, number one, and number two, we can actually work in collaboration with other service providers in the

city who are trying to work for that end goal, which is to support—

The Chair (Mr. Ernie Hardeman): Thank you very much. The next question is Ms. Gélinas.

M^{me} France Gélinas: If you are to think about the greatest needs of the population you serve and relate this back to the fact that we have the North East Local Health Integration Network, we have the North East LHIN, how do they connect? First, what are the greatest needs for the population you serve right now?

Ms. Shana Calixte: The greatest needs? It would be focusing on the issues around lower income and poverty. I would say that would be the most important, and also to reduce isolation, so having more services that provide day-to-day support for people to get them out of their homes. One is to combine that with more financial support.

What we see are people who are struggling to access housing, to access food specifically, and then something to do during the day. That's where I would see the needs are the most.

The second part of your question was?

M^{me} France Gélinas: Basically, when you talk about poverty, you talk about isolation; you talk about housing. All of those fall more or less outside of the mandate of the LHINs. So my question is, how does having a LHIN here help your clients?

Ms. Shana Calixte: How does it help our clients? Well, for us, it's talking about what kinds of services we can provide with the funding that we're provided. For us, the LHIN has decided that they want to see what kind of impact they can have for the amount of money they provide, and for us, it is about translating those needs—housing, income, those kinds of needs—into direct care. That has been one of the ways we've seen that the LHIN has supported us. That's how we see it.

M^{me} France Gélinas: Could you see a day where the LHINs would advocate for better income for your clients?

Ms. Shana Calixte: I would hope so, yes.

M^{me} France Gélinas: You would hope so.

Ms. Shana Calixte: I would hope so.

M^{me} France Gélinas: So really look at them as advocating for the needs of the population they serve, no matter if it falls within or outside their mandate?

Ms. Shana Calixte: Yes, and supporting organizations that do that kind of work.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in; just a great program. As Ms. Elliott said, what we heard on the Select Committee on Mental Health and Addictions was the need for the peer support, and so it's great to see this happening right here.

One of the potential criticisms of so many agencies involved in the mental health and addictions field—and it was articulated by Mr. McQuarrie from Nipissing—is that perhaps there's duplication in terms of administrative

costs. Has your agency looked at some of these back-office functions perhaps being merged in some way so that you could provide more to the front line?

Ms. Shana Calixte: We haven't, and mainly it's because we've gone from such a small organization of five people to now 35. Many of our positions are quite rooted in having that lived experience. For our specific example, we haven't looked at melding with other organizations because we don't want to lose that very important lens on saying that we've been there, we've had that experience, and peer support is really rooted in that. From the person who does admin to the person who does the janitorial work—every single one of us has that lens. For us, it hasn't been something we've looked at. Further down the road, it could be, specifically introducing or thinking about how lived experience of mental illness could be a part or could be introduced in every workplace. It could be something that we could see happening in the future.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Mr. Fraser?

Mr. John Fraser: How much time do we have?

The Chair (Mr. Ernie Hardeman): You have about a minute and a quarter.

Mr. John Fraser: Thank you very much for what you do, and thank you very much for your presentation. I wanted to ask you about the genesis of that eight-bed transitional unit, because it sounds like it's an example of collaboration. Can you tell us a little bit about how that came to be, who drove that and who the partners are?

Ms. Shana Calixte: Sure thing. It was the North East LHIN, along with the North Bay Regional Health Centre and CMHA. We have a couple of other partners who are also involved, and NISA. What had happened was, it was looking at the ALC crisis and thinking, "How can we move people out of the hospital and into community services?" This is really people who have high needs.

One thing that happened was, we came together to say, "First of all, where could they be placed and who could support them?" One place that they said that needed support mostly was through the staffing, so looking at who could provide that support through staffing.

We were asked to provide peer-support-directed staffing, so not just people who would be there to help people clean and cook, but really to focus on their recovery, so getting people out of the house, getting people learning skills—occupational skills and ADL skills, or activities-of-daily-living skills. So that's how it came to be.

It has been a really great partnership. It opened in June. It's very similar to Percy Place, which you heard a little bit about, that's happening in North Bay. It really has proven a really effective model, to have the peer support workers there to support people in their housing.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate the time you took.

CANADIAN RED CROSS, ONTARIO ZONE

The Chair (Mr. Ernie Hardeman): Our next presentation is the Canadian Red Cross, Ontario Zone: Heather Cranney, system navigator. Good morning.

Ms. Heather Cranney: Good morning. I'd like to thank you for allowing me this opportunity to speak. I originally looked at—

The Chair (Mr. Ernie Hardeman): Just before you start, I should advise you of the rules of the game, shall we say. Thank you very much for coming. You do have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's sufficient time afterwards, we will have questions from the committee, but you don't have to leave time for that. Thank you very much for being here. Your 15 minutes start now.

Ms. Heather Cranney: Okay. My name is Heather Cranney. I've been with the Canadian Red Cross for 10 years now and was originally a southern Ontario soul, like many of you. I grew up at Steeles and 48 and transitioned to northern Ontario in 1987. Officially they'll be changing my passport to reflect that after five more years.

I just want you to know that it really means a lot to me to consider this local part of our LHIN—it is very localized—and to say that they understand northern Ontario. That part is very important to me.

I started thinking about doing a presentation with charts and providing you a lot of information, but given the recent storms in northern Ontario, you have the gist of who Red Cross is in one part of our agency, which is our disaster management side, but to let you know, throughout Ontario, we have a lot of health care and community services.

Specifically in the North East LHIN, the Canadian Red Cross is funded for a variety of services, which include—I'll run them off real fast; don't take notes: transportation, home maintenance, friendly visiting, congregate dining, adult day, assisted living and meals on wheels, which we've been doing for many a year.

As well, in the last year, we've started into what we call a priority assistance to transition home—not transfer, because that just implies the ride. The transition is actually connecting community to hospital and a hospital-based service where Red Cross staff will travel home from hospital with a client and settle them in and make sure there's a report back to indicate: What was this first view of the home on the client's return? Were they safe to return home? Was there food in the house? Were there medications?

All of these things have now rolled out through the North East LHIN to Red Cross in all of our hubs. As you know, northern Ontario has four major hubs. We think that part is pretty exciting. We're really looking forward to impacting on the hospital ALC rate and discharge planning by connecting community to hospital.

My role as the system navigator is another, I think, stellar investment of the North East LHIN, because it

showed mostly that they were listening. We were gathered in a meeting in May 2011, the first time we really got the community support agencies in a room together. It came out loud and clear: We really don't have one voice. We really aren't telling each other what we're doing on a day-to-day basis in our operations. We saw a way to build, through the support of the North East LHIN, the system navigator positions, which have accomplished the support of a regional community support network, as well as localized community support networks, which have us talking, which is the true window to integration. I think that, in itself, is a real coup for the LHIN, to say that now they have a voice for the community and they are very strong, and we'll be knocking at their door often to say that this is what we collectively see as efficiencies to be developed in northern Ontario to better serve our clients.

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When I first started going to different tables, people spoke in the room with their cards held close to their chest. Now I find after the many, many LHIN committees I've sat on, we have our cards out there. You can see my hand is open to you, that we are actually looking at sharing information. We are looking at relationships I didn't see possible. When I see someone putting in a proposal that's very similar to something I might have worked on two years ago, I send them my stuff: "Here are things I've collected over the years," or I'll give them a heads-up that "I think this might be an opportunity for your agency." These weren't conversations, I think, that occurred five or six years ago. That's because the LHINs fostered this trust within our agencies. I truly believe that we're connected more than we ever were.

I look at really good decisions they've made, and besides the system navigation, some of them are that quick phone call when I have surplus funding at the end of the year. It's the Red Cross manager from Timmins getting rethermalization units for Meals on Wheels put in the remote locations, because our LHIN officer understands how hard it is to serve the town of Mattice in this community—that we wanted Meals on Wheels, but it couldn't be done. So we got a way to have frozen Meals on Wheels served warm to clients. We made them happy. What was even cooler was that we managed to get one of those units up in Moosonee, because in that community a lot of the elders were sending someone to the local store to get a burger and fries, and that was a consistent dietary staple. We ended up being able to use that to better serve the community.

Right now, my role is in a period of transition because the LHIN has recognized some of the needs of the First Nations communities to bring education, such as personal support worker training, to try to make it more able to serve their needs. They've actually called on me. That's my history with the LHIN: Sometimes they pick up the phone and ask my opinion. That's pretty flattering. They do it to everyone, not just me. They listen. Sometimes when I see something happen I can say, "That might have come out of a conversation I had." So I feel a connection

as a person and as a member of the Red Cross, and as a member of our community support network. I didn't see that in my earlier years. I've been in health care since my 20s, so it has been a long road, but I really see that the North East LHIN listens to me.

I see a personal connection to the officers of the LHIN—I sometimes say I know that Steve Belanger is trying to learn piano in Sault Ste. Marie, even though his family doesn't think he should. These other things that I know—they talk to me. I'm not just a person delivering a program; I'm an actual person. I like that I can walk into a room and that Louise Paquette knows who I am. She knows that I'm committed; I'm passionate. Someone from the LHIN told me, "It's infectious"—my commitment to the people we serve. I think the relationship is that I know that I can pick up the phone and say, "This isn't going to fly," or "Damn it, I want this for this community, so please listen," and I know that that will happen.

I really respect the work they're doing in First Nations now—the outreach—that they're doing. They've always understood.

When I worked more in Timmins, the challenge is that we have to be respectful of our francophone population—it's not just a language; it's a culture. I really had great experiences there in support with the LHIN to make sure the Red Cross was responsive and to make sure that we were able to serve those communities, as well.

I think that's enough. That was my passion for today. I'll take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about eight minutes left. We'll start with the third party. Ms. Gélinas?

M^{me} France Gélinas: It's nice to see you, Heather. Thank you for coming.

I will start with the tough questions that we read in the media. We hear people say that there are too many system navigators; there are not enough people actually delivering the care. Can you put that issue to bed for us?

Ms. Heather Cranney: I guess it's the definition of "system navigator"—a lot of the people who have the title "system navigator" are actually navigating the patient journey. In our system navigator role, we're looking at where the system didn't work. We're having tough questions at the hospital. At the CCAC, we're sitting at tables together. We're looking at CSS: "Why didn't you respond to that request?" We're not looking at Mrs. Smith's journey to and from. We're looking at why the system is letting her down, and not so much the actual people. Why did the system not work? We're trying to effect systemic change.

A lot of the other positions really are more patient-focused—like, say, they're diagnosis-specific or whatever. We're looking at the bigger system and things—in scope, out of scope. We see where housing failed. We see what needs to be rebuilt in transportation. We're looking at the system, and it's different.

There are four of us, so that's not a lot, to serve the incredible amount of geography that the North East LHIN serves. If you look at the map, it's big, just big.

M^{me} France Gélinas: The same question I've asked the other providers is: Right now, what is the greatest need of the people you serve?

Ms. Heather Cranney: Well, I'm prejudiced: It's the community. It's things that have gone by the wayside, that you used to have 10 years ago: home maintenance and supports to stay in your home.

Are we prepared for what's going to happen with low-acuity personal support? I don't see, maybe, the communication. That's at the Ministry of Health level right now, but that's going to be a very big change in how things are done. We don't know how it's going to flow. Are we ready for that?

I'd say, personal support and things that keep people in their homes. The health human-resources crisis—I've been involved at that level when the regional table—I don't say it's not something that we can solve. I just think we need a lot to put at that one.

As long as you consistently are funding, for example, personal support workers—the funding envelope and the way that it flows out, and the quality of care that we want to provide for our patients makes it very hard to maintain a workforce, and I think that's a really big challenge.

The Chair (Mr. Ernie Hardeman): Thank you. The government side: Mr. Colle.

Mr. Mike Colle: Thank you, Heather, for your personal presentation. I think that's really helpful in terms of getting the real human side of how these organizations work and how you basically work on a daily basis with them. I thought it was very helpful.

The question I had for you is, from your on-the-ground approach—we've heard a lot of comments as we've gone across Ontario about the need to get doctors, primary care providers, into the LHIN system. Because as you know, right now, they're basically still outside, except for the doctors who are at the community health centres. Do you ever run across any challenges with dealing with physicians and how to get them under the same tent?

Ms. Heather Cranney: I was just on what was considered a rock-star tour with Dr. Samir Sinha and the geriatricians from the North East LHIN. I got to observe their trip to Fort Albany and the First Nations community to deliver care and to create a very individualized plan of care for 27 members of the community, that had to be set up in such a way that the lack of, say, the rotating physicians and the lack of access to primary health—that when they came to the community, they were told very clearly that the next doctor who comes in here, who may not see this patient again ever, even, has to be able to say that you need to follow the directions that this stellar rock-star team of geriatricians has set forth for this client. They had to do this.

It was a great investment of the LHIN, but it was the idea that people are not getting primary health care. They

can only get seven minutes with a doctor. You might have five concerns; pick one. I see that often.

I do want to know a way—I don't have a solution—to have physicians that are very interested in working in especially the more remote areas of northern Ontario.

Mr. Mike Colle: What about a greater role, maybe, for these family health teams—I don't know how many you run across—or the nurse practitioners?

The Chair (Mr. Ernie Hardeman): Time. Go ahead—short answer.

Ms. Heather Cranney: Okay. I have been working with the health links in Temiskaming. I was on that committee—an opportunity for one of the early adopters.

I do see that the family health teams—I've watched their development. I sat on their board in Timmins and watched the development of them and as they expand, and they're having such a multidisciplinary team. Not everything in the world has to be done by a physician. My care was for 10 years with a nurse practitioner. I only met my doctor once in 10 years.

I do think there are a lot of models out there, and we need to pursue all of them. I do think a—

The Chair (Mr. Ernie Hardeman): Thank you. Now the questions go to the official opposition: Ms. Elliott.

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Mrs. Christine Elliott: Thank you very much for your presentation today, Ms. Cranney. It's great to see someone who's so passionate about her work. I applaud the great work that you're doing in the region. It sounds like there have been some great collaborations.

My only question would be, where do you see things going from here? What would you like to see as a next step in your evolving relationship with the LHIN? Are there things that you could see that could be improved, perhaps, or changed, or added on to?

Ms. Heather Cranney: I don't know. Sometimes it's hard to see. Sometimes, because we have cross-borders, like the North East LHIN onto the northwest Red Cross—it crosses into there and crosses into North Simcoe Muskoka. Sometimes, I find that it would be nice if a day came where there was a little more similarity in some processes, but I don't want to lose the uniqueness.

North East is completely different from North West, with different issues, so I would like some similarities across LHINs and some ways to transfer, but while maintaining my unique North East LHIN.

Mrs. Christine Elliott: Some deputants have indicated to us that it would be helpful to have a clear vision from the Ministry of Health, with some predetermined priorities that can then be implemented in more local situations. Would you agree with that, or do you think it would take away from the autonomy that exists here?

Ms. Heather Cranney: I always try to find my nice words. Some things which are excellent concepts at the Ministry of Health—I personally think of health links as an excellent idea, but I felt like it rolled out in such a pressurized fashion. I really, truly felt like it was handed down from the Ministry of Health to the LHIN—"Make this happen by Monday."

I do think the Ministry of Health needs to maybe be more aware of what's on the plate at the LHIN. They're about to launch this, but all of a sudden you've got a really quick RFP for the change in the physiotherapy and rehab. I don't know if they realize—they were kind of busy that day. You can't really write an RFP and have it out in two days. Sometimes, I—

The Chair (Mr. Ernie Hardeman): Thank you very much for your answer, and thank you very much for making your presentation today.

Ms. Heather Cranney: Thank you very much.

SAULT AREA HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presentation is the Sault Area Hospital: Ron Gagnon, president and chief executive officer. Good morning, sir.

Mr. Ron Gagnon: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in to share your time with us this morning. With that, you have 15 minutes to make your presentation. You can use any or all of that. If you have time left, we'll have some questions from caucus, to answer any questions they may have about your presentation. The next 15 minutes are yours, sir.

Mr. Ron Gagnon: Thank you very much, and good morning to all of you. As you heard, my name is Ron Gagnon. I'm the president and CEO of the Sault Area Hospital, which is about a three-and-a-half-hour drive to the west of here.

It's my pleasure to be here today to share my thoughts and observations as they pertain to the review of the Local Health System Integration Act. I share these from the perspective of a hospital CEO, someone who's been a hospital investigator and, more importantly, as a son, father and taxpayer.

My thoughts can be really summed up in two key areas or themes, the first being clarifying authority, accountability and roles of the different players in the health care system, and, secondly, facilitating integration and one true system for the person who is accessing it.

Let me start with accountability, authority and roles. Although LHSIA attempts to address these areas, I think it's fair to say that we're still experiencing growing pains. As a result, decisions and actions are slower than they need to be and, in some cases, are being made centrally as opposed to locally.

I would suggest that the ministry should be able to rightly focus on the provincial strategy for health and health care, and the needed provincial policy and programs to execute against this strategy. It should then be for the LHINs to work within those frameworks to deliver results on a local basis, by organizing the delivery of services in a way that best meets the needs of the populations they are accountable for and one that delivers the best value for the spending of taxpayer dollars.

LHINs need to be accountable for results—I'd suggest that they can do that through their accountability agreement with the ministry—and they should have the

authority to structure health care at the local level in order to deliver these results. They should not have to check each individual decision with the ministry, and they should not be left out of decisions that impact the delivery of services in their LHIN.

I have a couple of examples that will illustrate my point. First, a number of years ago, we worked very closely in our community with our community partners and with the LHIN to secure funding to help reduce the amount of alternate-level-of-care patients in hospital. The early part of this strategy included utilizing some beds that were freed up at one of our vacated hospitals. As we implemented strengthened programming in the community, the LHIN, the partners and the hospital all worked very closely together on these. We had established targets and we were working towards those targets.

In early 2013, the ministry directed that those beds were to close. However, the services in the community were not yet up and running. In some cases, those services weren't in place because of other LHSIA implications, and I'll touch on that a little bit later. In addition, each individual component of that original plan required ministry approval. As a result, the solution was not truly local, and individual programs were much slower in getting off the ground. This impacts the people who need the right service in the right place and who are now in hospital when they should be at home with the appropriate amount of supportive care, in a supportive housing bed or in a long-term-care bed, not to mention the added expense to the taxpayer as a result.

My second example has to do with ministry discussions or negotiations with primary care providers. We heard a question about that earlier. I've seen instances where the LHIN has not been part of these discussions at the local level until after something goes wrong or needs to be managed. Had the LHIN had some of the important information, different decisions may have been made and matters that escalated may have been managed differently. My comments should not be taken as a condemnation or a criticism of the Ministry of Health; they're not. My comments are examples, and examples are to illustrate the importance of clarity as it applies to accountability, authorities and rules. My comments are also to illustrate that the geographies and needs of the population in different parts of this province are different, and that those differences need to be able to be reflected in the structure and delivery of health services. I would say to you that one size definitely does not fit all.

Turning to integration, it's my belief that every one of us, every user of our health care system, wants and expects a true system, where all the players are focused on one thing: what's best for the person they are serving. The health system consists of many great people, all trying as hard as they can to do what's right. Unfortunately, our efforts are not always aligned and, as a result, we have siloed care as opposed to one systematic care system.

I'd also observe that there are opportunities to align the key parts of the system and I would recommend to

the committee that its deliberations seriously look at how to better align the providers in the system through alignment or their accountabilities, incentives or disincentives, and potentially through oversight of the LHIN. Legislation such as LHSIA and policy needs to lead to the partners in the system all making the decisions that are best for the patient.

I'll give you a small example of how our current system functions. Many family health teams are negated, or they get money taken away from them, if one of their rostered patients goes to another family health team or clinic. However, if that same patient goes to an emergency room for that low-acuity visit—a sore throat, or something that could really be seen in a primary care physician's office—there is no negation. Essentially, what we're doing is incenting people to direct patients to the highest-cost place in the health care system and adding to an already overburdened system of hospital emergency departments.

LHINs need to have a significant ability to align the health care system at the local level. This does not mean that provincial negotiations, policies or programs are not required. What it means is that the LHINs have the authority for the oversight of all key health care players so that the users of the health care system benefit from a system of coordinated care that is getting better value for the taxpayers' investment. How primary care is better aligned in such a system was one of the recommendations of the Drummond report and, I would suggest, should rightly be part of your committee's deliberations and recommendations. I'd also recommend that finding a way to include ambulance services and public health as part of the overall health care delivery system on a local basis be part of your recommendations.

Labour legislation is a major consideration with regard to health system integration and restructuring. LHSIA explicitly applies labour frameworks, such as the public sector labour relations act, to health care integrations. The applicability of PSLRTA to health care restructuring, or more specificity around when it does apply, should be considered.

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I can think of at least two examples where the fear of the costs associated with the application of PSLRTA have resulted in strategies that would have been better for system users and patients, and for the taxpayer, but have not proceeded. I can also think of at least one example where the fear of PSLRTA implications almost stopped an integration that was the right one for users of the system.

Amending the LHSIA to remove barriers for integration found in labour legislation will facilitate the changes necessary to improve the alignment and quality of patient care and reduce the cost of its delivery.

The last area I'll touch on is with regard to how facilitating an integrated system has to do with the powers of the LHIN to direct integration of organizations. Although many would believe—including myself until probably about 12 months ago—that LHINs have the authority to

direct the integration of organizations. In reviewing the legislation, it would appear that they do not.

They do have the authority to direct the integration of services, though most of that has been through voluntary integrations at this point. But they do not have the authority to direct the integration of organizations. At times, that may be what's necessary for a better and more cost-effective system of care delivery and health.

As the population of the province ages and the demands and needs for health and health care grow, a truly integrated system is needed so that it is easy to access high-quality care regardless of where you live, and it requires a system that is responsive to the needs of the people who live in the area being served. What it does not need is a one-size-fits-all approach.

In completing its work, I ask that the committee place emphasis on clarifying accountability, authority and roles of the different players in the health care system, and, secondly, facilitating integration and one system for the person who is accessing it.

I ask that, in the true spirit of continuous improvement, you build on what is working well to address what is not so that our parents, loved ones, children and grandchildren have a system they can depend on, not just for today but into the future.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about two minutes for each caucus, and we start with the government side: Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming today and giving us a lot to think about and a lot of suggestions.

I'll pick up on just one area, and I'll display my bias: I am a former medical officer of health. We've heard divided opinions as they relate to public health. In your comments, were you implying that there should be some sort of structural integration with public health into the LHIN as a sort of core responsibility of the LHIN?

Mr. Ron Gagnon: I think that possibility exists. It would be up for more deliberations and review by the committee. However, when I look at—and I heard one of the questions earlier: What are those key needs? There are a lot of, I would say, housing and social needs that maybe municipalities and public health could take on. Prevention is one of those key pieces of health that, I would argue, still hasn't gotten enough—

Ms. Helena Jaczek: We've heard very divided opinions on this, clearly, from the municipal sector, very much emphasizing that that particular municipality was very conscious of the determinants of health, and they felt that public health was a key role. Of course, there's the funding consideration for both public health and land ambulance.

On the flip side, do you have a relationship with your medical officer of health in Algoma?

Mr. Ron Gagnon: Yes, we do have a relationship with the medical officer of health. Actually, in Algoma, she's new. She started about six months ago, I'm going to say. We're building partnerships there.

The Chair (Mr. Ernie Hardeman): Okay, hold that thought. Ms. Elliott?

Ms. Christine Elliott: Thank you, Mr. Gagnon, for an excellent presentation. I was really interested with respect to your comments about the Ministry of Health and achieving alignment. You brought up the example of the family health teams and people being directed into the emergency department. What do you think should be done, from the Ministry of Health's perspective, in order to allow the LHINs to achieve their integration locally?

Mr. Ron Gagnon: The first thing, I think, is the strategy for the province: What is the vision of health and health care for the province—that is rightly the ministry's accountability—and then letting the LHINs work within that framework to deliver the key results that are being expected, as opposed to having to improve every individual program or initiative? I think if you want a true local solution, you have to give them some freedom.

Mrs. Christine Elliott: So it has to start with a vision that currently you're not seeing necessarily as a—

Mr. Ron Gagnon: I think the minister has done a pretty good job of articulating what she sees for people in Ontario; however, maybe we need to move that to a next step. When we look out 10, 15, 20 years, which is going to be a pretty big demand for health care in Ontario, where do we see our focus?

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Gélinas?

M^{me} France Gélinas: I was curious. When you first opened, you talked about the work that you did to bring the ALC population under control within your hospital, and then you mentioned that every step of the plan was delayed because the LHIN could not give you approval; you still had to go to the Ministry of Health for approval. Can you give me some ideas as to where it would have made sense for that decision-making to be with the LHIN rather than with the ministry?

Mr. Ron Gagnon: I would say the entire plan. We had key results that were agreed to; we had funding that was agreed to. Once you have those in place, it should then be up to the LHIN and the local community to deliver against those objectives. You shouldn't have to be checking every individual action plan. I realize that that means mistakes will be made, but if we want an innovative health care delivery system, we have to be ready to accept mistakes. The only way you get better is by making mistakes.

M^{me} France Gélinas: Could you give me a specific example of something where you had to wait for ministry approval before going forward—a piece of your plan?

Mr. Ron Gagnon: The operation of interim beds. We're still 18 months behind.

M^{me} France Gélinas: Really? Okay. You had the money—

Mr. Ron Gagnon: We have the money; we have the facilities; we have somebody ready and able to deliver the service in the community.

M^{me} France Gélinas: But you don't have the okay. I can see your frustration, and I see Louise smiling, kind

of. I think she would be willing to move in that direction also.

Mr. Ron Gagnon: I think she would as well.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for the questions and thank you very much for your presentation. It's much appreciated.

Just before I hit the gavel for lunch, lunch for the committee will be in the Courtview West room. With that, see you at 1 o'clock.

The committee recessed from 1200 to 1300.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. All present and accounted for, and no turkey for lunch, so we won't be falling asleep.

MR. DAN WATERS

The Chair (Mr. Ernie Hardeman): Our first presenter is Dan Waters. Is Dan here? Here comes Dan. Thank you very much for being here.

Mr. Dan Waters: Thank you for having me.

The Chair (Mr. Ernie Hardeman): As with all delegations, you'll have 15 minutes in which to make your presentation, and you can use any or all of it. If you don't use it all, if there's less than four minutes, we'll have just one caucus with questions, and if there's more than four minutes, we'll divide it equally among the three caucuses and use up all your time. Your 15 minutes starts now.

Mr. Dan Waters: I'm a bit long-winded, so here's hoping I have some time left.

We're here today to determine whether the LHINs are fulfilling their mandate. In a nutshell, the organizations within the scope of the LHIN would work beautifully together if it weren't for the inconvenience of patients. Don't get me wrong. The caring, trained, front-line staff who attend to people in the health care environment are top-notch. It's the hierarchy of the organizations that becomes troublesome.

A local health integration network in our area, first of all, isn't really in our area. Our area is Parry Sound-Muskoka, but our LHINs are the North Simcoe Muskoka LHIN, based out of Barrie, and of course the North East LHIN. It isn't really a problem that is isolated to health care or to the LHINs.

There is a town, actually, in central Ontario that is served by three LHINs. Rather than having three sets of ears to hear their health care needs, they have no ears to hear their health care needs. Each of the respective LHINs believes the health care needs are covered by the next LHIN.

When there is only so much money to go around, it's easy to see why one LHIN would want to pass costs on to another LHIN. How do we fix that? Is the answer to get another management team to watch over the LHINs? Where does this stop?

What we have is an umbrella organization that passes our health care dollars to other umbrella organizations. We have a LHIN that distributes funding to, in our case, seven hospitals, 26 long-term-care centres, one commun-

ity care access centre—that once again does not supply service; it's just an umbrella—three community health centres, 29 community support services and nine community mental health centres.

The North Simcoe Muskoka LHIN is responsible for \$815 million in funding, which is allocated to our 75 individual health care provider organizations. Each of the organizations operates within a service accountability agreement that details their funding, along with the performance targets and other requirements they are expected to meet. Some organizations provide more than one service. There are approximately 35 employees with the North Simcoe LHIN, and that's not counting the directors. If my memory serves me correctly, there are about six or eight who are on the sunshine list. And then, of course, the CCAC has people on the sunshine list as well—still no service to the individual.

Then we have the CCAC, which is another umbrella group. As mentioned in the opening of this presentation, this group would work beautifully together if it wasn't for the inconvenience of patients. The CCAC is a management group under the management group of the LHIN.

It has been said by the health care providers that if you become ill or need support during banker's hours, it's great; but if you are a human being who gets sick and needs support outside of banker's hours, you are a victim of the management groups.

These two groups allocate funding to hire services to the feet on the ground. The groups they hire also have management, of course. The problem is that by the time you get to the feet on the ground, the home care people, there isn't much money left, and they are paid poorly. In order to work in our area, they need to have a decent car and must travel a good portion of the day in order to see the excessive number of patients that they see. They don't get paid while they travel—which can be somewhere between half an hour to 45 minutes or longer—between patients. They get paid only for their patient care time.

According to the board chair at MAHC, which is Muskoka Algonquin Healthcare, our CEO also spends half of her time travelling, but, of course, she gets paid, and she does that to satisfy the LHIN. The highest-paid staffer is spending half of her time driving—a pretty high-paid driver, isn't she? It isn't just her; it's all of the smaller hospitals' CEOs. We need her at work in our hospital, not driving because she was summoned by the LHIN.

I'm not taking a shot here. Our highest-paid staff in our hospitals—and we have two under Muskoka Algonquin—need to be running our hospitals, not driving around central Ontario. In the case of North Simcoe Muskoka, an analogy used many years ago by Pierre Trudeau about living next to the USA was where he stated that it's like sleeping with an elephant: The elephant rolls over, and you're crushed.

It's the same thing with Parry Sound–Muskoka. The elephant is Barrie and RVH and Sudbury Regional Hospital, which are our two big hospitals. As much as we

love the two hospitals, the bigger they grow, the bigger their communities grow around them. The smaller communities between them lose services, and they don't grow. Then the LHIN needs to rationalize our services and make our community health care more efficient by reorganizing it in such a way as to dispense with the unnecessary personnel or equipment. What they really mean is to cut front-line staff and services. That's the reality of it.

Here's an example. We closed beds at South Muskoka Memorial Hospital, so they laid off staff due to the closed beds. To this day, the community supports are not in place to cover the needs, so the people who need care end up in an over-census bed in the hospital. "Over-census bed" means closed beds. There isn't enough staff to care for the patient load because of the over-census beds. There is a problem here because, in the current funding model, the hospital doesn't get paid for over-census beds, so they sink deeper into deficit. Now they need to cut more, and around we go, spiralling downward.

I live in Bracebridge. I have an autoimmune disease that, in my case, has affected several organs in my body, mainly my lungs—you wouldn't know by the way I talk. My specialist is in Toronto, and he teaches all over the world. If I were travelling to another centre to get advice on my condition, why would I travel one hour instead of two? Why do we put all our eggs in RVH?

Let me ask the question simply: Why do we have a new cancer care centre in Barrie, in the north part of Simcoe, and another one in Newmarket, which is just south of the Simcoe boundary, both of them serving Simcoe county? At the same time, they're stopping chemotherapy in Bracebridge because, according to the CEO of the local hospital, the LHIN and Cancer Care Ontario want chemotherapy only in one hospital in Muskoka, so it's going to the Huntsville hospital.

We need chemotherapy in both Muskoka hospitals. The chemo treatments exhaust patients, and they become nauseated. We need to remember that the function of health care is to care for people. These people travel for up to an hour or more to get to Bracebridge, and you're now forcing them to travel another hour round-trip to Huntsville.

If patients live in rural Ontario, there is no transportation service to help them get to their appointments, no matter where their appointments are. These people who need to travel have incomes that are not supplemented by any plan outside of CPP and OAS. Most of the people in Muskoka work seasonally and in minimum wage jobs.

Women who are homemakers have no extra support. As an aside, we have another little problem with health care; I didn't know about this until my mother passed away. Because she hadn't worked for seven years because she was disabled and was on compensation for the majority of her life from about 70 on—those people are not even eligible for CPP death benefits. When you've got low-income families, they rely on that to help bury their loved ones, and they don't even get that, even though she was on compensation all of those years. I

have an aunt who owned a business, and because back then you couldn't pay into CPP, she'll get nothing. She doesn't even get any CPP now.

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We need to remember the function of the health—I'm sorry. I digressed here.

The cancer society in our area requires \$100 up front to drive patients. The ambulances cost \$45 each way. There's no guarantee they will make an appointment because emergency transfer comes first. Transportation is a big problem in rural Ontario and for our small hospitals.

As we eliminate services in our small hospitals, more and more patients are required to travel. In Parry Sound, they use the air ambulance, actually, to move people to Sudbury for tests. In Muskoka, those people who have appointments in Barrie often miss them because the ambulance has exhausted its ability to cover both transfers and emergency calls. There are some private transfer services, but they drain the patient care budget from the hospital exponentially. The financial cost of running transport services, both air and ground, may be greater than leaving the services in the hospitals in the first place.

Add to that that the funding model pays hospitals for services that they provide. So if the patients are sent to Barrie for services they would have received in the past in the Muskoka hospitals, Barrie gets the funding for the service and the stat for using the hospital, and it becomes a self-fulfilling prophecy. The small hospitals, again, take a hit.

There are good things, though, happening, one of them being with the local fracture clinics, where the initial visit with a surgeon or a specialist in any of the bigger centres is followed up by appointments that happen right in our ambulatory care area of our local hospitals. We just need to expand on it.

We are here today to determine if the LHINs are fulfilling their mandate. In a nutshell, the organizations within the scope of the LHINs—and I'll repeat—would work beautifully together if it wasn't for the inconvenience of patients.

It appears to me that there are so many levels of management that siphon off front-line health care dollars out of the system, we are in a spiral downwards. The hospital is the hub of health care in our communities. We need to bring the services and management services back to our hospitals.

As a person who used to sit around this table when this outreach home care first came out in the early 1990s—the idea then was that in small-town Ontario, as you took the services out of the hospitals, you would bring up the community health care services into the hospitals. It would give them the funding to meet our needs of a hospital in our community there. It would also allow for service in the community. I think that you have to look at it.

I know that we need the LHIN, because before that we had regional health care centres. There will always be a LHIN. What I'm worried about is the levels of manage-

ment that are below the LHIN that really aren't performing any front-line service. They're not coordinating things.

I had a doctor talk to me last week. She had a patient come in on the Friday. She phoned the CCAC: "Sorry. We can't do anything until Monday. We just can't help them. We have no way to do that." Guess what? That patient stayed in the hospital for three days before they moved that patient out, instead of saying, "The doctor said they can go home. They need support. Here's the support." Those things are not happening.

I thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have exactly one minute, and it goes to the opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation today. You've raised a lot of concerns that other people have raised to us as well about not having enough front-line services available—too much being taken up in administration and bureaucracy.

You may be aware that the Registered Nurses' Association of Ontario has made a presentation and is recommending that CCACs be disbanded and that the function that they perform be brought into what the LHINs do. Would you support that as a way of eliminating layers of administration?

Mr. Dan Waters: As long as the bureaucracy doesn't—it has a tendency to, in government, grow. Within the LHIN, I look at how some of these things happen. We were encouraged to have Muskoka Algonquin Healthcare instead of Huntsville and South Muskoka hospitals as two boards and two managements. Really, we have just as much management and probably more ineffective management than what we had before.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. We thank you for taking time to come here to tell us about your concerns.

Mr. Dan Waters: Okay. Thank you.

MS. MARY ELLEN SZADKOWSKI

The Chair (Mr. Ernie Hardeman): With that, our next delegation is Mary Ellen Szadkowski.

Ms. Mary Ellen Szadkowski: I'm a delegation of one.

The Chair (Mr. Ernie Hardeman): Thank you very much for taking the time to come in to speak to us this afternoon. As with the other delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If there's any time left over, if there are less than four minutes, it will go to one caucus. If it's more than four minutes, we will divide it equally among the three. With that, starting now, it's your 15 minutes.

Ms. Mary Ellen Szadkowski: Mr. Chair, members of the committee, thank you for this opportunity to meet with you today and share some views from the front line, if you will. My name is Mary Ellen Szadkowski. I'm a registered nurse, retired. I have spent a number of years

in the health care system and have worked at many levels, including community nursing with the VON. I worked in nursing education; I worked in acute care. I spent some time with the Algoma District Health Council a number of years ago and worked with them as a health planner in mental health services. I've also worked in primary care and public health—I had a little stint in public health as well.

More recently, I started a consulting business. In that capacity, I had the opportunity to assist a family health team and two nurse practitioners get started, so developing their business plans and helping them to get launched.

That's the professional perspective that I have, but I'm here today mostly as a caregiver, as a family member of elderly relatives who have had experiences in the health system.

I just wanted to do a couple of things today. One would be to share some of their stories and perhaps make some suggestions based on the recent experience of family members, and then also reflect on my experience with the district health council compared to the LHIN today, how it's different and the strengths of it.

I'll begin with the story of some of my relatives. On two occasions, we've waited in the emergency room with frail, elderly relatives who sat for up to eight hours, waiting to be seen by a nurse. They were told during that time, "Oh, we're very busy." "Yes, we haven't forgotten you. We have other priorities right now." "No, we can't tell you how much longer it's going to be because there might be an ambulance case that comes through the door." In these cases, both of these patients left the emergency room without being seen. They had to sign papers to release themselves, but nobody seemed to care, and they left.

In another situation, the triage nurse was very quick to respond to symptoms of fever, nausea, vomiting and shortness of breath. This was followed up by a hospital admission of four weeks. The care that was received during that time ranged from considerate and respectful to dismissive and threatening at times. As a registered nurse, I was embarrassed by the behaviour of some nurses. I was asked by my relative not to complain. I said, "Come on; we have to do something about this." She said, "No, I don't want to do anything because it might affect the care that I receive. They might take it out on me," as it were. That concerned me as a health professional, that that was a perception that was there.

Although these experiences were quite upsetting, we are hopeful that with the Ontario Seniors Strategy and Dr. Sinha's report and recommendations—and recently, the LHIN had been facilitating discussions with the hospital to develop senior-friendly hospitals—we believe that these initiatives will be positive and will lead to some positive outcomes in the care that patients receive in hospital.

Following discharge from hospital, my 83-year-old aunt, with at least seven chronic diseases, who lives alone, received three baths a week from community care

access. After a couple of weeks, a coordinator came in to visit her, completed an assessment form and abruptly told her that her baths were being cancelled, even though she was still quite weak and unable to get to the bathroom and was unable to arrange all of the appliances in the bathroom to allow her to have a bath; it was very difficult. I acted as her advocate in that case. I requested the manager to review the situation, and after some discussion, she agreed to have an occupational therapist come in and do the assessment to determine if my aunt needed a bath. In the meantime, because that assessment was going to take a couple of months, she agreed to one bath a week. So at least we have one bath a week, but it was a bit of a challenge having to go through those hoops to make that happen.

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As I've heard today, with CCACs it seems that the focus is not so much on patient-centred care but on completing paperwork and reducing services. It also seems that there are ever-increasing numbers of case coordinators whose roles seem to be minimizing costs and eliminating services. I'm sure that's not correct, but it's a perception that I have at the front line. In the meantime, patients who are experiencing health challenges are often left at risk in the community.

The growing number of seniors in our community places a heavy burden on the system that was designed for a much earlier time, when home care and CCACs were introduced. Things were different in those days.

The cost of care at home, we know, is less than the cost to keep patients in acute care, yet when the services are cut, it leads to the revolving door that brings patients right back to the hospital emergency room.

The Canada Health Act identified five principles for health care, and two of these are comprehensiveness, which means that all necessary health services must be ensured, and accessibility, which means that all insured persons have reasonable access to health care. Canadians have come to expect to receive appropriate health care as an insured service. The delivery of health care services at home needs to be reassessed, with a strong focus on services in the home that are comprehensive and accessible.

In spite of the negative situations I've just described, there were two very positive things that happened for my aunt.

Before she was discharged from hospital, she contacted the Algoma diabetes education centre, where she has been a patient for 10 years. They had copies of her lab results and were quite concerned that throughout her hospital stay her blood sugar levels were three to four times higher than normal. Over the telephone, the nurse advised her how to adjust the insulin dosages. Within a couple of days, her blood sugar levels were back to normal. The nurses and dietitians in this program are the community experts in managing diabetes, and it's unfortunate that they could not have more influence in the management of diabetes among hospitalized patients.

Immediately after discharge, a registered nurse from the congestive heart failure program came to visit my

aunt at home, and through her interventions, other medications were adjusted and her symptoms were relieved. This nurse has been a critical part of the last 10 years of my aunt's stay at home and allowed her to stay there and be more independent than she would have been otherwise.

These two ministry-funded programs provide effective and efficient services that have had positive impacts on the health of their patients. Although they are accessible to everyone in the community, since the Group Health Centre manages them, many people think that they are restricted to only those people rostered at the Group Health Centre. The Group Health Centre is a primary care centre that is unique in the province, with an alternative funding agreement with the Ministry of Health. It's not a family health team or a family health group or a family health organization or a community health centre. It's a multi-specialty ambulatory care organization of independent physicians. More than 60 family physicians and a number of specialists work out of this centre. The Group Health Centre has more than 60,000 of the approximately 75,000 people in Sault Ste. Marie who are rostered members. Many of the non-physician services such as the anti-coagulation clinic are only available to members of the Group Health Centre. I think this has contributed to the perception that the diabetes and the congestive heart failure programs are only limited to people who belong to the Group Health Centre.

In addition to the Group Health Centre, primary care in Sault Ste. Marie is available through the family health team, the nurse practitioner-led clinic and a few family physicians in private practice. The family health team and the nurse practitioner clinics are required to participate in quality initiatives of the ministry and are accountable for the services they provide. However, because the Group Health Centre has a unique funding model with the ministry, it is not required to participate in quality initiatives and not required to provide information on any of their performance indicators, such as wait times for appointments, services provided, health promotion and education initiatives.

In order to ensure consistency, quality and public accounting of expenditures and outcomes, all primary care services should be included, along with the community health centres, hospitals and long-term-care homes, as health service providers under the act.

Over the past few years, the LHINs have had significant influence in moving to patient-centred care and away from provider-centred care. Many providers have begun to incorporate patient satisfaction surveys. While these scores are an important measure, they must be balanced with quality outcomes. On one hand, the staff may demonstrate care, understanding and hospitality to the patient and the family, which makes them feel satisfied; however, if the care has been substandard or does not follow accepted professional guidelines and has resulted in errors, the quality scores could be quite low.

Many resources are now available through Health Quality Ontario to assist providers to develop appropriate

tools and their processes for monitoring and improving their services. Requiring that health care providers use these will provide assurance that the methods used are valid and reliable, and will reduce the risk that providers have good answers but to the wrong questions.

In the early 1990s, I worked as the health planner for the Algoma District Health Council. We recruited many local residents to provide input and advice on health system issues, and we developed many plans to meet local needs. The DHCs were limited in their ability to effect change because all of the funding decisions were made at Queen's Park. There were times when we developed community-based plans and made recommendations that we were quite proud of, but they were not approved by the Ministry of Health. In some cases—and this my belief, my opinion—this was due to lobbying efforts on the part of local providers to have decisions made in their favour regardless of what the planning efforts had.

One of the major weaknesses of the district health council model was the lack of authority and the ability to hold providers accountable for meeting the goals or targets within the budgets provided.

The DHCs were excellent planners, and we had a wide range of data available. In the LHINs, this service has been enhanced through technology and the ability to provide a wide range of data quickly to assist others in health planning.

The Local Health System Integration Act decentralized decision-making on health system issues, and the new LHINs were given the power to make decisions based on evidence and input from local communities. While the LHINs have been given the authority and planning in the delivery of health care, confusion still remains because some community-based health services funded by the ministry are not required to report through the LHINs. Primary care, paramedics and public health are examples of organizations that have significant impact at the local level but are not included under the act.

In my experience, the LHINs listen, validate and take action to improve health care. They have led health care providers in moving to a patient focus. Back in the early days, it was uncommon to have patients or consumers at the planning tables for decision-making, but it's just standard and expected procedure these days under the LHINs.

A real strength of the LHIN, in my opinion, is the demonstration of transparency. All of us have access to information. We're allowed to attend meetings either in person or by electronics. We're always being asked to contribute ideas and suggestions. Accountability agreements between the LHIN and the health provider agencies are available and we can see what the results are.

The LHIN has made efforts to introduce innovative programs. One example of this is a pilot project in Sault Ste. Marie, where we don't have too many psychiatrists. It's done with the LHIN and the Ontario Telemedicine Network. When a primary care provider wants to have a patient seen by a psychiatrist, they could be seen through

the Ontario Telemedicine Network. A videotape is made and sent to a psychiatrist, who reviews the patient's history, renders a diagnosis and refers a treatment plan to the primary care provider, so that the care has some continuity. I think this is an example of how the LHIN has really supported us to be innovative and creative.

They also have taken major steps to help us become familiar with new education opportunities. They've led conferences of share planning between the district.

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In my opinion, the local health system integration network has been effective in improving our access to health services, improving coordination among local providers, increasing participation of citizens in health planning, and improving accountability and transparency in the delivery of these services. This review, I expect—with some additions that will be made, I'm sure—will help to make that even stronger.

I have three suggestions for you that I've discussed briefly: One is that home health care services be reassessed, with a focus on comprehensiveness and accessibility; that primary health care services be included as one of the health providers under the act; and that all health care providers be required, or at least encouraged, to use Health Quality Ontario tools to ensure their quality of service.

Thank you very much for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. All the time has been consumed, so thank you again for being here and assisting us in our endeavours.

SUPERIOR FAMILY HEALTH TEAM

The Chair (Mr. Ernie Hardeman): Our next presenter is the Superior Family Health Team: Alan McLean, family physician. Thank you very much for coming in and sharing your time with us this afternoon. As with the other delegations, you'll have 15 minutes in which to present your presentation. You can use any or all of the time, but if there's time left, if it's less than four minutes, it will be just one caucus getting questions. If it's more than four minutes, we will split it equally three ways. All that is somewhat irrelevant from here on. The next 15 minutes is yours.

Dr. Alan McLean: God bless you guys for sitting here all day like this, listening to people like me. I'm impressed.

I'll talk a little bit about why I decided to come here. I am a family doctor. I've worked in several different organizations. I started out fee-for-service. I've worked in the group health that Mary Ellen talked about. I've worked in a family health group, and I'm now working with the Superior Family Health Team and a family health organization. The other things I've done: I backed into a job as chief of staff at the Sault Area Hospital about eight years ago, so I was intimately aware of the relationship with the hospital and the LHIN from the beginning. I have a number of experiences around that,

and I thought I'd like to bring those to share about what the LHIN has accomplished going forward.

The other thing that I do is that I have become the primary care provincial LHIN lead for LHIN 13. It is an important role in terms of trying to get primary care integrated into the system. It also gives me the opportunity to go and talk to all the other LHIN leads and see what's happening elsewhere in the province. I do think it underlines the need for local decision-making processes in terms of health care. Downtown Toronto does actually have just as many challenges as we do in the north. They're very different challenges; they have to do with the diversity of population and huge density of population as opposed to huge distances. So to think that you could make the same thing work there as works here, I think, is somewhat crazy-making. But we do still learn from each other. There are still similarities, and I think it's important for us all to work together at the solutions and to learn from each other and steal solutions from other groups when it's possible.

Health care in Ontario is an incredibly complex system, as I'm sure you're all aware. There are multiple facets and a huge amount of bureaucracy, as I've heard a couple of the speakers speak to. But there are huge expectations in delivery. A lot of services are delivered to a lot of people, and it is difficult to pare down the bureaucracy when you're delivering that kind of care and the amount of costs that it includes. A little bit less bureaucracy in some cases would certainly be helpful, I think.

In terms of even the LHINs' function, I think local decision-making is important. Often, they get their hands tied by higher-ups in terms of limits in what they can do, and certainly, as Mary Ellen mentioned earlier, the fact that it's hard to integrate and coordinate when all the services aren't under their purview—the public health units, primary care. Anytime you're looking at doing a program to improve care and get everyone working together, we can ask them to participate, but there certainly is no accountability where we can ensure that they participate in programs going forward.

In terms of what I've seen in the last eight years, I think—I see Richard back there from CCAC, and I feel bad for him because my example comes from CCAC as well, but it is around an improvement, actually. About eight years ago, when I was chief of staff, the CCAC ran out of money in February. From February until April 1, the new fiscal year, they would take no referrals from the hospital. There would be absolutely zero patients getting services, coming from the hospital, at home. That, of course, left many patients stuck in the hospital, which is where your most expensive care was. That was crazy. That would never happen today, albeit they are looking at cutting services because of costs and because of the immense amount of services that they have to provide, especially with our aging population. But there is much more coordination.

Certainly, the ideal—and it would be difficult to know how to do this—would be to have the money follow the patient, so if there's funding for a patient, and they move

from the hospital into CCAC, the funding follows them, rather than this siloed approach of funding each organization separately. I'm not actually proposing that you blow the whole thing up and start over again, because I think that would take several steps back. In fact, in looking at that, going to the different leadership conferences for physicians across the country, it was a number of years ago that Alberta went from—well, first they were provincial, then they went to local and then they went back to provincial. There was such anger amongst the physician leaders and front-line staff when they were flipping back and forth. They lost a lot of leverage, they lost a lot of good people who went elsewhere, and they lost a lot of forward momentum in terms of switching back and forth.

I do think we had problems with the LHIN in the beginning changing direction, and frequent changes of CEOs as well. I think that has come around somewhat. There is a lot more patient contact and interacting with patients to figure out the mission of the LHIN and following that direction. I think they're just starting to fire on all cylinders a lot better, looking at integration, getting people working together. I think it's difficult to review them at this point. I know it's timely to do that; however, I think it needs another few years. I think if we start blowing up the system and going to another one, we'll go back five steps and then have to go forward all over again.

I think I had other things written down here but—you guys must get bored. No, I said all those.

I would also like to—

M^{me} France Gélinas: We have questions if you're desperate.

Dr. Alan McLean: Never desperate. In terms of my suggestions—we'll look for questions afterwards—I do think we should look at, overall, the better integration. I'm not sure the LHIN has the capacity right now to expand, but the ideal situation would be funding pots that are more totally controlled by a single organization, less siloed budgeting and more aspects where the money actually follows the patient. There certainly has been a proposal that—in terms of quality improvement, I think aligning quality improvement plans amongst all the different organizations would be helpful so that we can actually achieve—so you don't have different organizations fighting against each other. I think there would be a certain aspect of quality improvement leading to money savings, being able to reinvest those money savings in the community. I think that would lead to higher-quality cost savings and better quality of care for the patients. I do think that's why you folks are here and I think why most of the people in the audience are here. At the end of the day, it's about better care for the patients. I think we all need to remember that.

With that, I'd be happy to have any questions.

The Chair (Mr. Ernie Hardeman): Okay. With that, we have about nine minutes left, so the first question—we'll divide the nine minutes up three apiece, and it starts with the official opposition. Ms. McKenna.

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Mrs. Jane McKenna: Thank you so much for coming today and giving us your presentation. Obviously, you know the reason that we're having these is not for a Kumbaya session for everybody to come and tell us how great it is, but it's to get recommendations of how we can actually make it better. Besides your one—blowing up the whole system and having the money—

Dr. Alan McLean: That wasn't a recommendation.

Laughter.

Mrs. Jane McKenna: Yes, I know.

We would really just like to get some concrete recommendations of what to actually move forward with. So if you could tell us one thing, with all the expertise that you have and all the positions that you've had, that would actually make it flow better for the patient, what would that be?

Dr. Alan McLean: If I could have two, one would be the continuing engagement of the patients. I think you have to hear their stories and know what they're going through, and I think that needs to be the focus in terms of determining where your policies and processes go.

I think the thing we haven't done as much is engagement of the front-line workers. They have all kinds of ideas about what's happening, what makes them crazy in terms of things they're doing that is wasted time, and in terms of how to get the care to the patients. I think engaging them would help direct the system to lose all kinds of waste and benefit the patients at the same time.

Mrs. Jane McKenna: You're saying that the front-line people are the ones who have the frustrations and probably most of the answers about how some of the system can be fixed. Who are they actually giving that information to?

Dr. Alan McLean: Sometimes they feed it up the line. They often complain to physicians about it. Let me throw an example out there, just for fun. There are care coordinators in our hospital whose responsibility it is to get patients out of the hospital, to the appropriate place. Right now, our number of people going to nursing homes is too big. They will sometimes go in and see patients who are clearly not able to go home, no matter what services you put in, but they are required to go back to those patients to reassess them to see if they can go home, because our number is too big. Listening to them about the individual patients, they're spending a lot of time that they know is wasted, being required to do that, which is a bit of a problem. That's one that they expressed to me. I'm pretty sure they've expressed it up the line at their own organization. Again, the focus is on the big number.

If I could throw another one in there, too, in terms of—

The Chair (Mr. Ernie Hardeman): Thank you very much for the answer.

Ms. Gélinas.

M^{me} France Gélinas: Coming back to primary care, a lot of people have said they're quite satisfied with the work that the LHIN has been doing, and they're looking at expansion. Some of them talk about how public health

units should be planned and financed by the LHINs. Some of them have talked about primary care, which has to do with your line of work. Do you see value in having the LHINs decide where the next family health team is going to be; where the next community health centre is going to be; where the next nurse practitioner-led clinic will be; where the next aboriginal health access centre will be? All of those decisions are made by the ministry right now. Should they be made by the LHINs?

Dr. Alan McLean: Yes.

M^{me} France Gélinas: Why?

Dr. Alan McLean: I think they have a better idea of where the needs are, a better analysis of not only where the orphan patients are—the patients without physicians—and where special-needs groups are, so areas where there are huge rates of diabetes, or areas where there are certain groups of people who can't currently access care. I think they would be able to possibly place the chess pieces a little bit better, looking at it on a more local level than provincial.

The Chair (Mr. Ernie Hardeman): Mr. Fraser.

Mr. John Fraser: Thanks very much for your presentation. It was very thoughtful.

My question is about primary care as well, as you're the primary care lead. I want to come at it from a different point of view. I know you spoke about care coordinators in terms of hospital discharge, but from the primary physician point of view in terms of a patient coming from the community, how do you see what you're doing right now as a primary care lead—what do you see as a solution to, sometimes, a lack of connectiveness and cohesion that exists in the family health practice as it relates to the rest of the health system?

Dr. Alan McLean: There's a few different ways we're looking at doing that, and that is the focus of our primary care group at the LHIN. One of our focuses has been collaboration and co-operating with the CCAC. I think there has been a lack of communication both ways, from primary care to the CCAC and back, and we have formed a subcommittee to work with the CCAC on that.

The other big way we're looking at trying to get primary care in the loop is with the health links proposals that have come up. Health links involves getting all the different organizations—and primary care is required to be involved in that—to provide care plans for the neediest patients. I think that will get primary care working with all the other organizations—the hospitals, the CCAC, mental health, even nursing homes—and I think there will be ripple effects from that. They'll get to know the other organizations and will be talking about other patients too. I do think that we'll benefit from that. So that has been the focus of our primary care group as well, trying to move the health links system forward.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

NORTH BAY REGIONAL HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is the North Bay Regional Health Centre: Nancy Jacko, vice-president, planning, partnership, professional practice and chief nursing executive. That must be the whole administration of the health centre.

Ms. Nancy Jacko: Yes.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much for being here. As with the previous delegation, you have 15 minutes to make your presentation. You can use any or all of that time for that presentation. If there's time left over, we'll have some questions from the caucuses.

With that, the floor is all yours for the next 15 minutes.

Ms. Nancy Jacko: Thank you very much. As you know, my name is Nancy Jacko and I have that long, long title, and I think I get paid if I can say it right in a day.

I also have with me Mr. Phil Geden. Phil is the chair of our board. Also in the audience is Monica Bretzlaff, who is our regional manager of Behavioural Supports Ontario-North East.

Thank you for this opportunity to present to the Standing Committee on Social Policy, reviewing the LHINs' governing legislation, the Local Health System Integration Act, 2006.

Having the LHIN oversee our sector of health care in our LHIN 13 over the past eight years has allowed our organization to reflect on the impact of this oversight change. It is clear that it has taken a few years for the LHIN to establish processes and relationships with the varied care providers under their mandate in this vast geographical territory. As with any change, it took all of us time to understand their role and the accountability requirements. It now seems like the relationship has developed, and the benefits of local solutions have begun to provide positive opportunities for collaboration across the northeast.

You may not be aware that the North Bay Regional Health Centre is the product of three amalgamation processes spanning 19 years, the most recent one being North Bay General Hospital and the Northeast Mental Health Centre in April 2011. Prior to the decision to amalgamate, we had been ordered by the health restructuring commission of the late 1990s to integrate as many services as possible, as we planned to build and move into a new facility still being two corporate entities.

To integrate services, significant numbers of service level agreements were required to define relationships between the two organizations. This consumed a great deal of time for leaders in the organizations, and significant legal costs were incurred. Neither of these activities—I mean the time spent by leaders and the significant legal costs—enhanced patient care in any way.

Finally, the boards and senior leaders at both organizations came to the conclusion that a corporate amal-

gamation would allow us to dedicate our limited financial and human resources to providing the best care for the patient, both mind and body.

This amalgamation was complex, merging a regional mental health facility with a district general hospital. The LHIN, due to the restrictions to its powers, was unable to authorize an amalgamation. We, along with the LHIN, were required to follow many steps to seek the required approvals through the Ministry of Health to implement this positive change. Once again, this resulted in significant manpower and legal costs.

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There are many opportunities amongst the numerous health care providers with whom the LHIN has accountability agreements. Integration processes, in many cases, will be both resource-intensive and may not fully realize the quality of service and efficiencies that amalgamation would.

To achieve the truly best results that the LHINs are accountable for and the people of the province expect, they must have the authority to execute the required system changes with local stakeholder input. Collaborative opportunities orchestrated by the LHIN have brought both hospitals and community providers together in joint planning and projects. Transparency of shared data amongst the organizations has created the ability to establish and share best practices, resulting in improvements to care and the patient experience across the north-east.

For example, following the development and implementation of our North East Behavioural Supports Ontario initiative, we have been witness to impactful system transformation. Through the LHIN's leadership, we've experienced a renewed focus on inter-sectoral collaboration, which has helped dissolve historic barriers and enabled the implementation of collective best practices. The end result is a program that was built on stakeholder input and addresses the unique needs of our region.

To truly improve system navigation, transitions in care, wait times, costs, staff and patient safety, and quality of care, the entire continuum of care must be accountable to one another. Currently, primary care, composed of family physicians and nurse practitioners, as well as public health units, are not under the authority of the LHIN. Their impact on the other health service providers that are accountable to the LHIN leads to fragmentation in the provision of care and subsequent inefficiency. For example, the initiation of a health link in our area has required a separate process to engage physicians when most of the other key providers are at the table at the call of the LHIN. Ideas to improve care, such as health links, are very innovative. However, implementation may become onerous when prime partners must be rallied to participate and have the option to decline.

To sustain and improve the current standard of health care, system transformation must occur at an accelerated rate. Optional integrations will not occur quickly enough. Radical changes made in isolation to balance budgets

may have unintended consequences for the entire system, eroding the quality of care. LHINs must have the breadth of authority to implement these changes at a local level with stakeholder input and measurable outcomes to ensure the best use of resources and, ultimately, the best quality of patient care.

In summary, the North Bay Regional Health Centre believes that in order to get the very best quality and safety in patient care, accompanied by the best use of limited resources, we recommend the following:

The LHIN's breadth of responsibility should be augmented to oversee at least primary care and preferably public health and other health care organizations within the LHIN.

The LHIN should have the authority to initiate and approve integration or amalgamation of services within its area.

The terms of reference for such integrations or amalgamations must allow local solutions to occur, taking advantage of particular best practices within each area of the LHIN.

The terms of reference should mandate local consultation before any implementation occurs, but the final authority should rest with the LHIN.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about eight minutes, so we will each have two and three-quarter minutes. We start with the New Democratic Party, the third party: Ms. Gélinas.

M^{me} France Gélinas: Okay. I think you were in the room when I asked the previous presenter, Dr. McLean, about bringing some funding and decision-making authority to the LHINs. You have it as one of your key recommendations for primary care. Could you explain to me the breadth of primary care that you would like rolled into the LHINs? Or, as you say, the responsibility should be augmented to oversee at least primary care. What size of the primary care pie are we talking about?

Ms. Nancy Jacko: We're speaking about all our primary care in the way of physicians and our nurse practitioners; those are the two that I was thinking of, that have the most impact in our relationship in the community.

M^{me} France Gélinas: So that would include all of your solo fee-for-practice etc.?

Ms. Nancy Jacko: Yes.

M^{me} France Gélinas: Okay. Do you know if that idea has support within your realm of influence, with the people you know?

Ms. Nancy Jacko: I would say, certainly, with some of our—do you mean physicians or do you mean other health care providers?

M^{me} France Gélinas: Everybody you know.

Ms. Nancy Jacko: I think that you would certainly see it with many other health care providers, because we all have our ability to meet together, but there's a different relationship with primary care.

From a physician perspective, those who have probably embraced more modern practices, like your family health teams, would probably be more amenable, because

they also see the connections in the systems. It might be a little bit more challenging with your independent practitioners, because they've stayed that way because it's the way they like to operate.

M^{me} France Gélinas: You said "preferably public health."

Ms. Nancy Jacko: Yes.

M^{me} France Gélinas: So you would like public health to also be under the responsibility of the LHIN?

Ms. Nancy Jacko: Yes. We increasingly see such a connection with the hospitals, with all the things with infection control measures, the outbreaks with long-term-care homes. They have a great deal of work with all of us across the whole sector.

M^{me} France Gélinas: The second one, I don't really get: "The LHIN should have the authority to initiate and approve integration or amalgamation of services...." They already do.

Ms. Nancy Jacko: Integrate, but not amalgamate. In the case of boards, they can't order boards to make decisions, and with us—

M^{me} France Gélinas: That's what you mean by "amalgamation"?

Ms. Nancy Jacko: Yes.

M^{me} France Gélinas: It's amalgamations of agencies. Because they can already do integration of services, now it would be amalgamations of agencies.

Ms. Nancy Jacko: Yes.

M^{me} France Gélinas: Okay. That would be not only the agencies themselves but their boards, their letters of patent, the whole thing?

Ms. Nancy Jacko: Yes.

M^{me} France Gélinas: Okay. You don't see any downside into losing boards of directors?

Maybe I'll ask this to you. A board of directors brings the governance. They are usually not-paid volunteers who give you the long-range planning for your agency. Do you see any risk in losing those?

Mr. Phil Geden: I suppose it's just the fact that people are going to feel threatened, I guess, to a certain extent, but so what? I mean, it has got to happen. It's all on the basis of the best patient care. It's as simple as that. So I don't think so, no.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time there. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for coming in. As MPPs, probably one of the biggest complaints we get from our constituents is patients being discharged from hospital and that transition, whether it be to long-term care or whether it be to the home, is problematic for many people. I'm looking at this from the patient's point of view. At the North Bay Regional Health Centre, do you still have a position called "discharge planner"?

Ms. Nancy Jacko: We have a very strong discharge-planning process in our hospital. Actually, our ALC rates in that are very, very good. We work very well with our community partners.

Ms. Helena Jaczek: You also have a care coordinator from the CCAC.

Ms. Nancy Jacko: We do.

Ms. Helena Jaczek: So there are two individuals planning on the process. Is that how it works?

Ms. Nancy Jacko: Yes, and they plan together. Actually, we co-locate them in the same office so that there is a duplication of processes, so that they each cover their own area that needs to be covered, and it works very well.

Ms. Helena Jaczek: I guess we've heard a lot of concern about over-administrative practices with the CCAC, that the CCAC essentially just brokers direct patient care. Do you subscribe to any of that, from your observations?

Ms. Nancy Jacko: It's all in how your relationships work. If you keep the patient at the centre, you're not going to be duplicating services. What you're going to be ensuring is that the patient has the safest discharge, and that's what we aim to do.

Of course, there are always restrictions of funding and those other things that we can't change, but we try and work together, bringing in all of those services and working together to achieve the best transition for that patient.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. I'd just like to follow on from Ms. Jaczek's questions. Just to understand, what is the responsibility of your discharge planner, and what's the responsibility of the CCAC care coordinator? How is it they don't overlap?

Ms. Nancy Jacko: One of the things is, you can't bring in your care coordinator without a referral. What our discharge planners do is look at high-risk patients who come in. They see almost each and every one, because we have them assigned to the different areas. They help navigate that patient's course to discharge.

If, at some point in time, CCAC services are required, the CCAC is brought in, but sometimes those services aren't required. They work with families. If families are going to take the patient home, maybe the CCAC isn't required. Maybe a community support service will do the role, so a CCAC may not be involved. There are different patient groups that could be dealt with, strictly with the discharge partners; other times, the CCAC is required to be brought in for the complexity of that patient.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much for your presentation.

Ms. Nancy Jacko: Thank you.

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PEOPLE FOR EQUAL PARTNERSHIP IN MENTAL HEALTH

The Chair (Mr. Ernie Hardeman): Our next presentation is People for Equal Partnership in Mental Health: Joel Johnson, family program manager.

Mr. Joel Johnson: Good afternoon.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here, and good afternoon. We thank you very much for coming in and sharing your time with us. You will have 15 minutes to make your presentation, and you can use any or all of that time for your presentation. If there's time left over, if it's less than four minutes, we will have just one party ask questions; if it's more than four minutes, we'll try and divide as equally as I can to all of the three parties.

I just wanted to question, before you start your time: All day, we've been moving farther down the table. I think you're the first one that's looking for the door.

Mr. Joel Johnson: Where have we started?

The Chair (Mr. Ernie Hardeman): On that side, but it's okay. No, it's okay. I say that in jest. You can take any—

Mr. Joel Johnson: Not at all. Actually, I could just slip up front with you there, and we could work it as a television opportunity.

The Chair (Mr. Ernie Hardeman): There you go. With that, I'd better start your time. The next 15 minutes is yours.

Mr. Joel Johnson: Thank you very much. I'd like to say thank you for bringing the select committee together and for taking a close look at this, because I think that this is a very opportune time in the development—especially of the provincial strategic plan, especially around mental health—for bringing a little bit of a check mark into place and taking a look at where we're at and where we can go from here.

We have a couple of facts that we'd put on the table. First of all, we have an aging population. The demographics are such that, in the northeast region, the largest segment of the population are aging. We call ourselves the baby boomers, and we require and demand good, solid health care and equal, equitable access for all of the citizens in our region. It's one of the things we demand as citizens of our province.

We're a big province. I sat as the president of the Ontario Peer Development Initiative, which is the provincial voice, if you will, of consumer-survivor initiatives, community mental health agencies that deal with peer support and consumer-survivors. I sat there for six years and worked with the ministry and some of the LHINs, both down in Toronto and up in the north here, and one of the things that struck me is that the LHINs are as varied as the population, and the solutions are as varied as the population as well.

I wanted to set that as the baseline for some of the things that I'd like to say next, because I really want to look at this perhaps a little more philosophically. Although the devil is in the details most of the time, it has to come from the right value system, and it has to come from the right strategic plan.

With the consideration that we look at our citizenry from a physical and mental health perspective—both those living in the heart, if you will, of downtown Sudbury and on the coast of James Bay—we look at

them with the same lens and the same service paradigm in mind. We have to start considering what the LHIN has brought into the system by coming down to a regional level.

I'm going to speak specifically of our district, which is the Nipissing district—and North Bay particularly, because that's where I serve—but I have to look at the differences between how we worked with the ministry prior to the LHIN and how we've been working with the LHIN.

It's been a long, long road, but one of the things that I discussed with my team before I came here is, I asked them to give me a definition or to draw a line between the words “revolution” or “evolution” of a system. To a member, around the table, we decided that, from an evolutionary point of view, there is sustainable growth and sustainable movement towards patient-centred care and towards enhanced value for what we provide. That can sometimes mean that we provide more, as community agencies, as hospitals, as CCACs. It can often mean we provide more, or often it can mean that we have built efficiencies into the system.

One has to, of course, look to what has facilitated that. I have found and our team has found that over the years now, as the LHIN has come into its own, if you will, the process in our district has been descriptive as opposed to prescriptive. Through that descriptive process of engaging with our senior policy analysts or what have you and having them attend our district tables where we make decisions for community services in our district, they bring to the table with them an understanding of what the LHIN has available, what the region has available, the movement in the various aspects of their top three priorities or what have you. They bring that to the table and then discuss with us, each and every one of us at the table—we have all of our agencies represented at our district table, as well as a consumer representative, a family representative, and we have a discussion with our LHIN representative as to our next steps forward.

We have built a partnership with our LHIN, and the partnership looks an awful lot like we're an advisory body, and then other days it looks an awful lot like we have a need and the LHIN is our advisory. But at the end of the day, not any of it has been prescriptive. There have been things that have had to be done and we've all had to come to consensus on it. Sometimes that consensus is difficult. It calls to mind, of course, the silos, which I'm sure you've heard lots of throughout the day today. But from a strength-based point of view, I can honestly say that I haven't met a person in our system who has anything but the good of the patient, the good of the client, the good of the member, the good of the citizen at heart. We're all doing our job to the best of our ability, and sometimes that has required a whole lot more. It's difficult to hold and retain highly qualified staff sometimes with, of course, the freezes on salaries and so on, but the LHIN always manages to find a way to assist us in the process of moving the system forward, sometimes collaborating with each other, sometimes just offering

some of their expertise around how other districts have managed or dealt with a situation that we may be dealing with at the time. So I find them a phenomenal education resource as well.

The main driving point for us—and this is a bit of a feel-good story, yes. If you're looking for recommendations from me as to what I would change, that's coming.

Our perspective, and I'm here representing a number of us in our district, especially around peer support—peer support has been a phenomenal opportunity in the district and we're starting to realize gains in it. But another thing we're starting to realize: I'm only one step removed from the grass itself. My feet still hit the grass, so I understand what people are saying because they're saying it to me too. I manage a process, I manage some staff, but I'm right in there with them, with sleeves rolled up. As a matter of fact, I wanted to make a point here.

What I'm looking at is I'm looking at the LHIN and our policy analysts and our integration analysts from Sudbury, from North Bay, what have you, providing us with facilitation. They don't stipulate; they facilitate—strongly worded suggestions at times, out of necessity, always with a ready explanation, and sometimes the explanations don't always add up at the end of the day either, but that is evolution, isn't it? That is what we do when we evolve a system as opposed to radically altering or changing to meet the political will of that particular decade.

It struck me as odd—amusing but odd—the research department in Toronto that I was working with said their expectation was that results would be forthcoming in 12 to 15 years. My comment was, “Gee, I really hope I'm alive, because I want to know how this works out. I hope I make it that long.” But that is evolution, and that's what it takes sometimes.

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It's a complex system, as has been said, I'm sure, numerous times. It's a complex system with very complex needs and demands, with an ever-burgeoning population with the requirement—and not always the funds available that would address that; the same dollar-per-person value that we've perhaps enjoyed in the past. So that's where we're at right now.

From the perspective of the LHIN, then, our team finds, not just as a partner, but as a funder, that they have been fostering change and assisting with change management in ways that only a local understanding of the system—again, I'm speaking more from a mental health, community agency perspective at this point. Only a local understanding of the system could bring forth the change management that has been required over the past couple of years, as the LHIN has truly come into its own.

The one very strong recommendation that I would put forward—and this is consensual, from all of the team members I spoke with before I came today: We ask that they stay the course. For crying out loud, don't change too much now, because we're on a roll. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have enough for the circulation, about two and a half minutes each. We'll start with the government side. Mr. Fraser.

Mr. John Fraser: Thanks very much for your presentation. It was very thoughtful. I appreciate the fact that you talked with your team before you came and that you had a discussion about this. Obviously, there was a lot of collaboration.

I understand your recommendation, but I want to ask you, in terms of your organization, what role do you play? You're a family program manager. Just for my own edification, what does that mean?

Mr. Joel Johnson: Interestingly enough, in the realm of peer support in mental health, we basically have two groups. We have consumers and consumer managers—those are managers of staff who work with consumer-survivors, or consumers, as you will. On the other side, we have family programming, with family staff. Each and every one of us, especially at People for Equal Partnership in Mental Health, are either consumers of mental health services who are employed by PEP, or consumers or family members working in the family program, also at PEP, who have lived experience with family. I have a brother who has a serious and persistent mental illness, so I am a family member. I deal with it on a regular basis, and therefore I can come at it from that perspective.

Did that come close to what you were looking for?

Mr. John Fraser: Yes.

The Chair (Mr. Ernie Hardeman): Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Mr. Johnson. It's very encouraging to see so many groups involved with mental health that have come forward to present to us.

We still hear, though, that the system is still very fragmented, and I'd be interested in hearing from you about what the LHIN is specifically doing in the mental health area to create more of a unified system to make sure that no one falls through the cracks.

Mr. Joel Johnson: That's a good question.

Mrs. Christine Elliott: Thank you.

Mr. Joel Johnson: I come from a background of lecturing at universities, which is why I think they sent me. Nonetheless, to keep it short, I would have to say that what the LHIN does is they move into our district, they come into our tables, they talk with us and they bring forward where we need to go.

I'm going to talk about “integration” here, because I happen to think it's a great word—it's right in there with “collaboration.” “Okay, we need to do this. We need to bring some of you together. We need to help you to partner.” That's what they do. They come in and they facilitate the partnerships that are required, without directing us specifically as to how to do that.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): The third party? Ms. Gélinas.

M^{me} France Gélinas: I will start my questioning the way I did with most others. What would you say are the top needs priority for the clients you serve?

Mr. Joel Johnson: Continuous access as they require—

M^{me} France Gélinas: Access to?

Mr. Joel Johnson: Access to services. I don't want to get too specific, but I'll say, from a mental health perspective, access to mental health services when they require it and in a way that they can access it freely—"freely" meaning, of course, that the time and the place is to their advantage, not disadvantage.

M^{me} France Gélinas: Okay. So problems with access, as in, the services are not accessible when they need it or where they need it?

Mr. Joel Johnson: Accessibility is directly linked to capacity.

M^{me} France Gélinas: Wait-lists, you're talking about?

Mr. Joel Johnson: That could be one of them, yes.

M^{me} France Gélinas: Okay. So that's your number one. What would be number two?

Mr. Joel Johnson: You know, when I said, "stay the course," ma'am, what I was really saying is that I think a number of my issues are being addressed and the issues of the system are being addressed as an evolution. My number two issue, of course, is the ability to train people from all of the different perspectives that the client requires or that our member requires. For instance, if it's peer support, I want trained peer support workers; if it's case management, I want trained case management people available, and I want them on the ground and reaching out—not waiting; reaching out. But that requires capacity, as well.

I promised myself I wasn't going to hammer on the capacity issue but, at the end of the day, my issues revolve around the ability to enhance or increase capacity in a smart way that doesn't continually bloat the system but serves the paradigm that's being developed right now, which is a care paradigm unseen in the past, quite frankly.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time allotted, so we thank you very much for your presentation, and maybe we'll start the flow again.

Mr. Joel Johnson: Thank you all.

FINLANDIA VILLAGE

The Chair (Mr. Ernie Hardeman): The next presenter is Finlandia Village: David J. Munch, executive director. Good afternoon. Welcome and thank you for coming in today. You will have 15 minutes in which to make your presentation. You can use any or all of that time for your presentation. If there's time left over, we'll have questions and comments from caucus. With that, your 15 minutes starts right now.

Mr. David Munch: Excellent. Good afternoon, Mr. Chair, and everyone here today. Thank you for allowing

me to present. My name is David Munch and I am the executive director of Finlandia Village, and have worked in the seniors' housing and health care sector for the past 18 years. I'm here to speak to you today about Finlandia Village and how the North East LHIN supports a northern Ontario community.

Finlandia Village, for those of you who don't know, is an aging-in-place, or what we refer to as a continuum of care, for seniors. I'll give you some quick facts about what Finlandia Village is all about. We're located here in Sudbury. We were founded in 1982 by the Finns of Sudbury as a charitable non-profit group. Currently, on site, we have over 400 residents with about 250 staff and over 100 volunteers strong. We have a 99.7% occupancy and we are accredited through Accreditation Canada. We have agreements with the North East LHIN with our, what's referred to as an M-SAA, which is referred to for the community side of our assisted living, and with an L-SAA operating agreement which is for our long-term-care side of our organization.

It all started at Finlandia Village with affordable housing. Back in 1985, we constructed and built 90 apartment units and offered support services to aging seniors. Over the last 30 years, we've been able to build six projects on site, offering that continuum of care in the form of 30 life-lease townhouses, 218 apartments made up of one- and two-bedroom units, eight shared seniors accommodations and 110 long-term-care beds.

Finlandia Village's experience with the LHIN has been excellent in many different areas, but today I will focus on just one that is its most recent, which is assisted-living services for older adults—not just assisted-living services for older adults, but affordable assisted living, which means any senior in the province of Ontario who is on a minimum or modest pension of anywhere from \$1,300 to \$2,500 a month can afford to live there. That means they can pay their rent and get assisted-living services provided to them to help them live as independently as possible.

I think the name of the LHIN says it all: north east, local and integration. Developing solutions for our community in our latest Lepokoti apartment development, the North East LHIN provided integration support to bring together various forms of the government, namely the Ministry of Municipal Affairs and Housing, the Ministry of Health and Long-Term Care, the North East CCAC, Canada Mortgage and Housing, and our municipal government. I think you've heard the term earlier; it's breaking down silos. We had all these forms of government working towards this project.

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This project was 82 apartment units of self-contained apartments of one and two bedrooms, with rents as low as \$600 a month. That's affordable for a senior on a minimum pension. What did the North East LHIN do to support this project? They provided funding for personal care, with 24/7 PSW staffing on-site to care for the 50-plus residents who needed assisted living.

Another thing they did which was unique and creative was that before this building was rented up, we identified people in our community who lived in long-term care and didn't need to live there anymore. I ask the question: Who do you know that's moved into long-term care and has moved out back into an apartment, into the community? Long-term care does an excellent job caring for our residents, bringing them back up to health, giving them physio services and proper medication services. We identified a handful of residents in our community to move out of long-term care into assisted living, into this building, thereby getting people in for the right care at the right time, which is part of our focus.

As well, the LHIN supported senior-friendly design: How about building an apartment building with a congregate dining room? How about a multi-purpose space for residents to be able to have their activities in? How about designing fully accessible shower units and toilets: not doing it after the fact, but putting in those grab bars during the construction process, putting in those raised toilets during the construction process, to allow people to move in—maybe independently, maybe at full service—as they age in place, in their home, in their apartment, and can be cared for?

I am convinced that without having the North East LHIN provide a leadership role in the development of this project, it wouldn't have happened. I probably would be sitting with you here today rhyming off a list of excuses of why this didn't happen. I would tell you that the housing forum of the government doesn't fund health care. I'd probably be telling you that health care told me they don't fund housing. The municipal government would be caught in the middle. CMHC—Canada Mortgage and Housing—and the North East CCAC would be waiting for something to happen, because they know the demand that's out there for this type of housing in assisted living. The most important part is that seniors would be waiting in our community for a place to move, to call Finlandia Village their home.

So that's what has happened in the last couple of years. What I'd like to look forward to, with this group, are the next steps.

Working with the North East Local Health Integration Network to enable our continuum of care to transition residents who call Finlandia Village home, we would like to look at opportunities to internally transfer from one level of care to another, so taking the opportunity as a continuum-of-care organization to have somebody in assisted living move into the long-term care on-site to stay in their home, or quite possibly those living in the long-term-care home who don't need those services anymore being able to transition on our site to our assisted living project. Right now there are certain barriers to entry on these areas, and we'd like to continue to work with the North East LHIN to challenge the legislation, with the challenges that we have in this area to move forward.

I hope the 14 LHINs in Ontario continue to be supported by the government and that their role in the communities is maintained and expanded. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about eight minutes left, so I think we start this round with the official opposition. Ms. McKenna?

Mrs. Jane McKenna: I just put a candy in my mouth, so I apologize. Anyway, thank you so much for coming in.

I'm just curious. You started in 1982, correct?

Mr. David Munch: Yes, that's correct.

Mrs. Jane McKenna: What did you do prior to that, considering the LHINs started in 2006?

Mr. David Munch: We were funded through the Ministry of Health and Long-Term Care in some cases. But over the 30-year history, we were able to construct new buildings. In the original parts, the early years, it was more independent housing. But what our society noticed was that people moved in back in the 1980s when they were in their 60s. Now, 20 and 30 years later, they are in their 80s and 90s, and we need to provide assisted living services to them.

The other key ingredient was that the apartment buildings that were designed back in the 1980s and 1990s weren't designed to have people live in them into their 80s or 90s, so bathrooms were smaller and kitchens were bigger in those times. Under our new design criteria, we're designing smaller kitchens and bigger bathrooms to allow people to age in place.

So we have been working with the health care establishment for the last 20 years.

Mrs. Jane McKenna: What are your age demographics?

Mr. David Munch: It's age 65-plus. Each building differs, but, believe it or not, the average age in our assisted living is older than in our long-term-care home. The average age in our assisted living is, I believe, 84 years old on average, and in our long-term-care home, it's 82 years old.

Mrs. Jane McKenna: If you could think of just one thing that could make the system better, from what you're doing right now, what would that be?

Mr. David Munch: More affordable assisted living. Anybody can build apartments and charge \$1,300 or \$1,400 a month. Unfortunately, for seniors in Ontario over the age of 65, the minimum pension is \$1,300. There are many people receiving only \$1,300 to \$2,000 a month. Where do they go? They can't afford a retirement home. They do a great job servicing the community. But they have no affordable place to go.

If you live in a house in certain parts of Sudbury, built in the 1940s or 1950s, there are physical limitations in that house: narrow hallways, narrow doorways, stairs to enter. What we've noticed at Finlandia Village, with aging seniors, is the mobility and the barriers to entry. You have to make things barrier-free and allow them to access the areas they need to access.

Mrs. Jane McKenna: Thank you.

The Chair (Mr. Ernie Hardeman): The third party: Ms. Gélinas.

M^{me} France Gélinas: I was very interested in the last comments that you made in your presentation, about how people within Finlandia Village should be allowed to go from one level of care to the next.

People love Finlandia. When I get a complaint about Finlandia, it's always the same thing: They were in your assisted living, in your apartment; they were admitted into the hospital, and they now need long-term care, and they get shipped to anywhere-but-Finlandia long-term-care beds. Do you have a solution for that? When you talk with the CCAC or with the LHINs—if you were the decider, what would you change?

Mr. David Munch: I've actually had discussions with the CEO of the North East LHIN and the CCAC. My issue was, change the legislation. That's one of the reasons why I'm here today. We need to add into the legislation for the CCAC to recognize continuum of cares, to allow these people to transition to the right care at the right time. I do agree that there are people in the greater community who need access to it as well. But when you've had somebody live on a site like Finlandia for 10 or 20 years—their friends are there; in some cases, their spouse is residing in the apartments for assisted living—we need to have a formal procedure to allow that to happen. I do think the CCAC try to do that as best they can, but it doesn't always work out, as you hear from your constituents.

M^{me} France Gélinas: So you would make it that if you've lived at Finlandia, although you may not be the highest on the priority list when one of your long-term-care beds opens, you should be allowed to go into one of those beds.

Mr. David Munch: That's correct.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek?

Ms. Helena Jaczek: Following up on this barrier, as you've described it: Are each of your facilities independent corporations?

Mr. David Munch: No. They're one corporation.

Ms. Helena Jaczek: I'm just thinking ahead, as to how, if one wanted to amend the legislation—so they are currently a resident, as an example, in the assisted-living part, and they would like to get into the long-term care of the same corporate structure.

Mr. David Munch: Yes. One of the things we've identified is, assisted living goes to the person, not the apartment. Anybody can live in an apartment, but it's the age and the frailness of the senior that gets the assisted living. What we're looking for is, individuals in a continuum of care, like Finlandia, who are living in an apartment but getting high-level assisted-living services, and who no longer can live there safely, who need to transition to long-term care—allowing those individuals to transition into our long-term-care home when the availability comes up.

Ms. Helena Jaczek: Does the assisted-living piece of your corporation fall under some sort of retirement home

legislation? We put forward retirement home legislation. Would you have to accord with that legislation?

Mr. David Munch: No, we don't. We fall under apartment legislation. We are building self-contained apartments with full kitchens, full bathrooms—one-bedroom units. These are apartments anybody can rent in our greater community. So we fall under that legislation, and then, because we receive funding from the North East LHIN, we fall under the Ministry of Health and Long-Term Care guidelines for assisted living.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We appreciate it.

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MEALS ON WHEELS SUDBURY

The Chair (Mr. Ernie Hardeman): The next presentation is Meals on Wheels Sudbury: Kelly Zinger, executive director. Thank you very much for making the time to come and see us this afternoon. As with all delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's time left over, we'll have questions from the caucuses. With that, they're your 15 minutes.

Ms. Kelly Zinger: Good afternoon, Mr. Hardeman, Madame Gélinas, other members of the Standing Committee on Social Policy, Ms. Paquette and representatives from the North East LHIN, community agencies and guests. My name is Kelly Zinger and I am here today as a representative of Meals on Wheels Sudbury in my role as executive director.

Meals on Wheels Sudbury is a non-profit charitable organization with more than 40 years of history serving residents within the city of Greater Sudbury and its outlying areas. We are a community support health service provider that receives annualized funding dollars from the North East LHIN as a component of our annual revenues.

Meals on Wheels Sudbury offers nutritional meal programs to members of this community who are unable to manage or prepare meals on their own. Our clients represent a wide spectrum of people who live in and around Sudbury, including seniors who require support services in order to remain independent in their homes, convalescing individuals recently discharged from hospital with limitations to preparing healthy meals at home, persons with disabilities, persons dealing with mental illness, and caregivers of clients. Meals on Wheels Sudbury is a unique meal program provider as we operate our own social enterprise: Home of Our Own Catering. Our catering business, which also serves the catering needs of the public, is responsible for the contract that prepares all hot meals for Meals on Wheels Sudbury clients.

Last year, our agency supplied more than 34,000 meals to over 440 residents of the Sudbury area. These meals were delivered by a dedicated team of loyal volunteers. Although our volunteer numbers have decreased

over the last few years, our drivers continue to support our programs by logging more than 85,000 kilometres each year to ensure our meals are delivered daily to all clients.

Historically, Meals on Wheels Sudbury has been a leader in the community support services sector. We have a reputation for leading change and advocating local and provincial governments for reform and improvements in our sector. As such, we are represented on a variety of local and provincial networks, committees and associations. Two important collaborations of note are the Ontario Community Support Association and the Sudbury-Manitoulin Community Support Services Network.

At the provincial level, Meals on Wheels Sudbury has been a long-time member of the Ontario Community Support Association through participation on various committees and their board of directors. The OCSA plays an advocacy role for all CSS health service providers throughout the province and is a key player in legislation reform for the sector. The OCSA provides an avenue for CSS agencies in Ontario to share best practices in service delivery and support professional development, ensuring all Ontarians receive quality health care where it matters most: in their home.

Locally, the Sudbury-Manitoulin CSS Network is an assembly of 12 North-East-LHIN-funded CSS agencies that provide services to the area. We have a mandate to share and adopt best practices in the CSS sector to support the goals of the North East LHIN's integrated health service plans and to provide a method of communication amongst CSS providers, the North East LHIN, North East CCAC and Health Sciences North.

The network has received support from the North East LHIN through regular representation and attendance, which has contributed to opening the lines of communication between our sector and our funding arm. Additionally, regular representation from the North East CCAC, Canadian Mental Health Association and Health Sciences North has supported open dialogue and discussion between the CSS and other health care sectors.

The establishment of the LHINs province-wide in 2006 was born out of the idea that the provincial health care system needed, and Ontarians wanted, a localized approach to health care planning and allocating of government funds for health care service providers. Meals on Wheels Sudbury was incorporated into the North East LHIN and has since signed multiple agreements that align the agency with the North East LHIN's integrated health service plans and local priorities.

Over the past eight years, each of the 14 different LHINs have developed and transformed as appropriate to their local area. Although the Ministry of Health and Long-Term Care establishes and defines the key health priorities for the province, it has fallen to each individual LHIN to interpret and realize these priorities. Interpretation of Ontario's health priorities as they relate to specific communities offers localized solutions; that is, 14 different solutions to similar challenges.

The Local Health Integration Network Collaborative was created to collectively address the issues and concerns common to all LHINs and allow open communication between the 14 CEOs to share successes and challenges. At times, the LHIN Collaborative has missed opportunities to communicate the sharing of many experiences of the various LHIN projects, which has led to duplication of initiatives and some project failures in various LHINs. For example, implementation of the Great Plains financial software system through CCIM was mandated by some LHINs for all health service providers, yet only recommended for use in other areas of the province. Also, the experiences and trials of those who have transferred systems were not commonly shared; thus, we still do not have a system that ties all agencies and organizations together. Those health service providers currently in the process of transitioning to the GP software system have no insight from providers who successfully made the switch. In order to succeed as a system, we must remember that the sharing of ideas, achievements and experiences of one LHIN with the rest of the province will ultimately benefit all Ontarians.

Meals on Wheels Sudbury is a partially funded health service provider of the North East LHIN and thus it is possible for me to speak directly to some of the successes and challenges of this particular LHIN. I wish to comment on a few key areas that Meals on Wheels Sudbury feels are reflective of positive system change with the evolution of the North East LHIN and where improvements can be made to improve the health service delivery to northerners.

The North East LHIN has taken many strides and achieved a great many successes for their part in the overhaul and reorganization of the funding processes and practices in northern Ontario. Chief among these successes is the local allocation of government funding dollars. For years, northerners wondered why southern-Ontario-based government representatives were given the authority to determine where our northern health care dollars were to be spent. Now, under the Local Health System Integration Act, 2006, monies are allocated to the health service providers based on needs determined by local North East LHIN representatives.

Additionally, advanced requirements for agencies to submit data and financial details on services provided have supplied the North East LHIN with the mechanisms to make evidence-based decisions when allocating funds. Although it is not yet a perfect science, the value of data collection and appropriate financial oversight is now emphasized and supports a more accountable and credible health system.

The focus of all LHINs has been to enhance and embrace community and home support services in order to decrease the public's reliance on acute care services. It is well known that the cost to the taxpayer is greatly reduced when people are supported in their own homes rather than in long-term-care and hospital settings.

I urge the North East LHIN to use the evidence from the financial and service reports they receive on a regular

basis from their health service partners when making decisions related to funding allocation. Increases to base funding in the community support sector is a necessity. The North East LHIN must recognize that the administrative and support costs of health service providers are constantly increasing. Although the North East LHIN has provided slight increases to funding through enhanced project funding, it must be recognized that the CSS sector went without increases to base funding for a great number of years. These increases have only allowed CSS health service providers to begin catching up to their health care sector counterparts.

The North East LHIN has greatly enhanced its visibility and communications with members of the health care community and the general public over the past few years. Through interactions with the local and regional media, rarely a day goes by without mention of the North East LHIN and their current activities and interactions.

The North East LHIN offers an informative and easy-to-navigate website for quick reference and topical updates within the regional health care sector. I would recommend that the North East LHIN utilize their media contact and website resources to share with the northeast community the unique successes and developments of other LHINs.

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Rather than working in a regional bubble, creating new and improved processes, health service providers in the north should be looking to other provincial programs and activities, to share innovative ideas and concepts. What has been tried and tested elsewhere may be applicable in some form to the northern health care community.

The North East LHIN has improved accessibility and contacts to government-level representatives for agencies such as Meals on Wheels Sudbury. Our agency has access to a local CSS representative who oversees our portfolio related to funding. This individual is available for regular meetings and discussions and has an intricate understanding of the specific operational needs of our agency. In addition, the North East LHIN has introduced the role of the CSS system navigator within each of the hub hospital areas in the northeast. These navigators allow for system issues to be addressed with the coordination of all health care sector partners. As a local CSS agency, it is encouraging to have a voice at the table where information is presented and decisions are made.

It would be easy for me to stand before this committee and narrate various difficulties encountered by small, local agencies like Meals on Wheels Sudbury over the years, since 2006. However, no new organization develops flawlessly. Instead, I would prefer to offer support and encouragement to the LHINs and the ministry as we continue on the path of developing a localized health care system. There are areas in which the LHINs and, more specifically, the North East LHIN can improve and become more effective in their processes. There is a need to promote the evolution of the LHINs. Much change has occurred over the past eight years, and I expect we will

see more. Change takes time and investment. Both the government of the day, the health service providers and the general public need to realize that positive change will not happen in isolation or overnight, but as an open dialogue among all participants, in a constructive format.

I wish to thank the Standing Committee on Social Policy and the North East LHIN for the opportunity to present the opinions and thoughts of Meals on Wheels Sudbury. I look forward to reading the final report and to continuing my role in progressive change.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about three minutes left, so we'll go to the third party. Ms. Gélinas?

M^{me} France Gélinas: Thank you very much for coming, Ms. Zinger.

You mentioned the need for the administrative support of Meals on Wheels and other community support agencies and how there have been flat-lined budgets in your sector for a long time. Would you be able to elaborate a little bit more as to what you're looking for? When you speak to the LHINs, how does it go?

Ms. Kelly Zinger: What I was referring to was the cost of having properly trained individuals within our organization. The funding that we receive from the LHIN is not enough to support an adequate number of trained staff. We must fundraise and receive donations on top of that, and increase our client fees. What we're looking for is an increase to our base funding so that we can have these properly trained individuals on our staff to properly care for our clients. When I speak to the North East LHIN representatives, they hear what I have to say; they understand it. It's a matter of where we find the money. There isn't a lot of money out there to be spread around. There's no more money coming to us—we realize that—but it's how it's distributed amongst all the health care sectors.

M^{me} France Gélinas: You were not included in the 4% increases that were given?

Ms. Kelly Zinger: We only received a partial amount of that.

M^{me} France Gélinas: How much do your clients pay right now to receive Meals on Wheels?

Ms. Kelly Zinger: Our clients pay between \$7 and \$7.25 per meal.

M^{me} France Gélinas: What's the difference?

Ms. Kelly Zinger: If you're a diabetic client, you pay \$7.25. Also, if you're receiving a frozen meal, it's \$7.25.

M^{me} France Gélinas: You've talked about all of the community support services getting together. Is this supported by the LHINs?

Ms. Kelly Zinger: Yes, it is. We have regular representation on this committee. They attend all of them, and they relay our information back and forth.

M^{me} France Gélinas: And then, when you go to province-wide, you've talked about mistakes made in some parts that were repeated, that could have been—how do you see this working better?

Ms. Kelly Zinger: Better communication, sharing of ideas, and sharing of successes and challenges. How one agency may have implemented a new assessment tool in one area of the province should be shared. Whether it was a success or they incurred a challenge in that, it should be shared amongst all, so that we can learn from our experiences. For one agency to just—

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, and thank you for taking the time.

SHKAGAMIK-KWE HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next delegation is Shkagamik-Kwe Health Centre: Angela Recollet.

I just wanted to say to the delegation that it doesn't matter how I butcher the names; Hansard will report them perfectly as printed.

Thank you very much for coming in and meeting with us this afternoon. You do have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's time left over, we will have questions from our caucus. With that, the next 15 minutes are yours.

Ms. Angela Recollet: Perfect. Can you hear me okay? All right.

Remarks in Ojibway.

Bonjour. Je m'excuse; je ne parle pas français.

Remarks in Ojibway.

I've just introduced myself in our traditional language of Anishinaabemowin. This is the territory of the traditional people of the Anishinabek Nation. Je ne parle pas français, so I will provide my presentation in English, so that we can all understand what I'm here to share with you.

My English name is Angela Recollet, and I come to you in my role as the executive director of the Shkagamik-Kwe Health Centre. More importantly, I come to you as a daughter, a mother and a grandmother of three, with another binoojiins on the way, but for my presentation's sake I will present to you in my role as the executive director of the Shkagamik-Kwe Health Centre. Shkagamik-Kwe, in our language, means "Mother Earth," and this is the Mother Earth healing centre.

I want to give you a little bit of the history of the 10 aboriginal health access centres in Ontario. So, a little bit about the AHACs, as we'll refer to them—and I won't go word-by-word, verbatim, of the presentation. I'll just have an informal discussion with you about the history of the AHACs, what our current state is and where we would like to be, but more importantly to speak a little bit about first peoples in what you now call Ontario, and what primary care needs they have—or, if we could be honest and say, "What primary care for first peoples in what you now call Ontario?"

In Ontario, you have 10 aboriginal health access centres. The AHACs were created through the Aboriginal Healing and Wellness Strategy, the AHWS strategy,

several moons ago, under the Ministry of Community and Social Services.

Shkagamik-Kwe is about 15 years old. We're going into our 16th year. In our lobbying efforts throughout the years, we made a transition to the Ministry of Health and Long-Term Care. This transition took place about four years ago, so now we are currently under the Ministry of Health and Long-Term Care.

It's quite a gem that the province has in the AHACs, because there is no other kind in what you call Canada. From coast to coast, these are a very unique health care system that is mirrored by the community health centres in Ontario. It really is a true gem in Ontario, providing the primary care that we are able to provide to first peoples, whether you're in an urban centre or you're coupled with First Nations communities.

All 10 are very common in our approach to healing and well-being, and that's coupling western practices of medicine with our traditional approaches to healing. That's the core foundation of how the AHACs have been created, and it really honours and sustains our cultural values and systems in how we care for our people in our communities.

As you know, history has not always been the kindest when it comes to first peoples in Canada, and that's no different here in Ontario. But we are a very strong people, and we take pride in ensuring that we continue that development of the seven generations.

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As I stated earlier, I am a grandmother. The decisions that we make here today are going to affect those babies who come tomorrow. We always need to be mindful of the things that we do with pen and paper and how that impacts our future.

A little bit about the AHACs: We are very unique but still similar in our approaches, as I stated. The geography in Ontario is quite vast, so you can appreciate the different locations of the 10 AHACs and the populations that they serve.

One of the unique qualities of the AHAC that differ across the province is the population. We have some in larger urban centres, such as Toronto—is an aboriginal CHC, which is very much like the AHACs as well, and hence where we were mirrored from within our creation. We have centres in Ottawa that serve a very high population of First Peoples, Métis and Inuit. This is simply because of the Eskimo project that took place many moons ago, that brought Inuit people into the large city of Ottawa.

We're very unique in our approaches, but still very common in our plight to ensure access to primary care.

Like our Association of Ontario Health Centres—our provincial association that the AHACs moved to, probably five years ago—we also see a future without systemic barriers that prevent people from reaching their full health potential, a future in which everyone can make choices that allow them to live a full life.

I'm not going to go into all of this. I'm not good at reading things. I'm really good at just visiting and telling a story.

If we could talk about the LHINs and some of the successes—as you know, you're here as a standing committee to look at the social standing of the LHINs in Ontario.

For us here in the north, our North East LHIN is fortunate to have three AHACs that are in the catchment area. There has been some dialogue over the past little while on whether we should be moving under the LHINs or whether we should be staying where we are within the Ministry of Health and Long-Term Care. Because we're a sector of 10, the AHACs have agreed that it's critical that we maintain our unity within our lobbying efforts within the ministry, to ensure that our voices are not getting lost in the system.

Although we have a phenomenal relationship with the North East LHIN and the administration here in the North East LHIN, our other counterpart AHACs do not have the same. So in order for us to move, we have to be considerate of not losing our values system and our core, fundamental approaches to our primary care, and respecting our traditional values.

That's one of the quick answers, how I respond, and I believe that my colleague AHAC EDs would respond in the same context: that we have solid relations with some of our LHINs, and we don't feel at this time that it would be appropriate to move into the LHINs' structures until we can look at some parity and some inequities that face the AHACs in our delivery of primary care within the ministry, and until the ministry identifies what a strategy could look like in Ontario for aboriginal primary health care.

Another piece with the LHINs: The mandate of the LHINs is too focused on the integration of the sickness system, and it doesn't have a health-and-well-being mandate. Culture is treatment, and that's the motto that the AHACs take with all of our service delivery. Because of the void in the psyche that our people have been faced with, with colonial practice and residential school truths, we need to ensure that we get back to the basics of our cultural fundamental values, and for us, that's healing and community. That's the core part of how we deliver our service. In everything that we do, culture is treatment. We treat wellness, as opposed to having to treat illness further down the line, although we are still in the midst of having to undo the intergenerational trauma impacts that history has imposed on us.

Second, the 10 AHACs across Ontario are in a position of serious underfunding. I'm not going to sit here in front of you and tell you about all the underfunding. I'm sure that you've heard this right across all of your deliberations, about the resources it takes to deliver so-and-so. It's not always about the financial resources. It's really about streamlining and utilizing the existing resources, and putting focus on the areas that are successful in delivering primary care services.

The final point: The LHINs need to institute a First Peoples population needs-based planning approach. We

know about the poorer health outcomes of our people, yet there is no First Peoples health care plan for the province. Under the act, the ministry was required to establish an aboriginal and First Nations health council and aboriginal planning entities. Six years after the act was passed, neither has been established. This does not signal that the health outcomes of our people are a priority for the province or for the LHINs.

I'll speak to this point in a little bit more detail and talk about some of the political challenges that we face in what you now call Canada. You have federal governments, you have provincial governments, you have municipalities and then you have chiefs and councils. In all of these relationships, there's a fiduciary responsibility put to the feds and not to the province. So until we can get past this invisible border and look at all Ontarians or all peoples living in this vast territory and ensure that they have equal access to care, then we're not going to identify solutions to offer primary care to First Peoples.

In our North East LHIN, we have made substantial strides in addressing some of our coastal challenges, but if you've ever been to our fly-in communities—and how many of you have?—then you will know some of the disparities that our communities are faced with when it comes to simple health care, simple primary care. So that, in itself, is a huge challenge.

Until we can get past some of the political disputes around where the responsibility lies for the Nishnawbes, whether it's federal or provincial, we're not going to have equal access, because we too are people. We're not subhuman by any course. We've been here for a very long time, and we plan to be here for many, many moons to come.

I come to you in respect so that you can make some healthy decisions and look at the choices that we're moving forward so that all Ontarians, including the First Peoples, Métis, Inuit populations—and that we put aside some of these differences but still focus on the differences that have been laid out, not by us, in order to access primary care in Ontario. Meegwetch.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. We just have one caucus with questions. Mr. Colle.

Mr. Mike Colle: Meegwetch, and thank you for your very clear presentation. We've had a number of community health centres give presentations with this LHIN review. I know myself and others were very, very supportive of the community health centres because they really are hands-on in the community. There aren't all the layers of bureaucracy, and they really connect with people on the street. I guess the AHACs are really a First Nations version of that.

Do you employ primary care physicians or nurse practitioners? Who do you have on-site?

Ms. Angela Recollet: Absolutely. Okay, so I'll give you a quick overview of the complement of the practitioners that we have within our agencies, our organizations. So we couple primary care, western and traditional. At Shkagamik-Kwe, we have four NPs. We have a full-

time pediatrician, so that takes up one of our FTEs for our physician envelope. We have two part-time physicians who work with us. Remember, we're located here in Sudbury, so access to recruitment and retention initiatives for primary care western practitioners is sometimes easier than going into the rural areas or the First Nation communities for recruitment and retention of the physicians. We also have three traditional doctors—or, as some would call them, healers, but I look at them as our doctors as well—with their helpers. So to us, those two are treated equally as specialists in their respected fields.

Our core funding comes from the Ministry of Health and Long-Term Care in several different branches. We have our diabetes envelope, so we have a nurse dedicated to diabetes, a dietitian who is also a certified diabetes educator. We have another envelope from the Ministry of Children and Youth Services that funds our FASD initiatives, along with our healthy food for our kids, so our Healthy Choices Program; some of the admin—which is very limited, and therefore our resources are spread thin with our existing administrative support to deliver programs.

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We also have chiropody within the centre. We have health promotion. Our traditional component is a huge component to what we do at the centre because, again, everything at the core of what we do is culture treatment. So we do have a full complement of western practitioners who are employed at the centre on a full-time basis in a salaried capacity, and that, again, includes the four NPs and the two FTs for the physicians.

Mr. Mike Colle: I think you've made it very clear that you have a good relationship with the North East LHIN, but, on the other hand, you want to keep that strong, united voice of the 10 AHACs. Is there anything that can be done in the interim?

Ms. Angela Recollet: We've already taken action for the interim. Relationships are critical for me, and I believe that everything that we do is based on relationships: relationships with each other, within our human family, relationships with our plant life. We utilize all of the plants in our traditional approaches to healing; our animal kingdom, as well, because we believe good food is good medicine. We've taken the initiative to build relationships with Louise and her team and we've been having talks with the four of us. We've initiated that on our own accord, once we tried to start finding solutions.

Now, also note that all of the AHACs have MSAA agreements, so we all do access funding from our LHINs, but with our core funding coming through the Ministry of Health and Long-Term Care negotiations branch. I won't get into the politics of that today, but we do have MSAA agreements, and we do, I believe, within our LHINs, have a healthy relationship. I can tell you that the other AHACs do not. Other than our South West LHIN, that is the only other AHAC that has a very solid relationship because they happen to be in Deb Matthews's riding, so Deb has taken the time to build that relationship.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your time, but I'm somewhat surprised by your last comment. I thought it was because it was in the Chair's riding.

Ms. Angela Recollet: There we go. That's probably it too.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

NORTH EAST SPECIALIZED GERIATRIC SERVICES

The Chair (Mr. Ernie Hardeman): Our next one is the North East Specialized Geriatric Services: Jo-Anne Clarke, leading geriatrician.

Dr. Jo-Anne Clarke: Hello. I'm not a health planner and I don't speak well from notes either, so we'll see what we get. I'm speaking on behalf of the North East Specialized Geriatric Services. I was recruited here in 2009. I think the story of our service speaks to the value of local health planning.

I was the first geriatrician to come to northeastern Ontario and remained the only geriatrician here until September of this year, when we were lucky enough to recruit another geriatrician. However, the planning for geriatrics started before that. The Regional Geriatric Programs of Ontario, at the time chaired by Michael Borrie, as well as Cal Martell, who were part of the regional planning group for geriatric programs, had made several visits when they learned that there was a northern school of medicine being founded in northern Ontario. They knew that funding for geriatrics and underfunding of geriatric specialties, as well as programs, was often a barrier to the development of geriatric programs and so started to plan, knowing that funding initially to create regional geriatric programs was tied to the medical school, saying, "Now that you have a medical school, how are you going to work to develop geriatric programs and potentially a regional geriatric program for northern Ontario?"

I also happened to be mentored by Dr. Borrie, who then told people not to recruit me, that I was from Sudbury and I was going to come back to Sudbury and we were going to develop geriatrics there. When I was graduating, I made a site visit to Sudbury and we met with all of the local groups, including the North East LHIN, the hospitals, the CCAC, as well as community supports to look at how we would develop geriatric programs for northern Ontario if you only had one geriatrician.

At the time, it was a challenge. The word was that the ministry was not going to be funding more regional geriatric programs, that that was not something they were going to do in that manner. The normal groups that would support geriatric programs at the time were not in a position to do that. I would have to say that the North East LHIN was very creative in creating the North East Specialized Geriatric Services to meet the local needs. We paired it with the aging-at-home funding which came

through, and the city of Greater Sudbury, which was a municipality, was selected as the host and led the way for developing the program. For the first five years of North East Specialized Geriatric Services, we were administered by the city of Greater Sudbury through funding from aging-at-home dollars.

We were told quite clearly when we received this funding that we would be a regional program, so although we're going to be located in Sudbury, it was up to us to look at developing geriatric programming for all of northeastern Ontario.

We built our program reflective of the regional geriatric programs of Ontario. We focus on clinic service delivery for the frail, older adult. We look at capacity-building in education to develop best practices for geriatric care across northeastern Ontario. We also look to be responsive to the unique needs of northern Ontarians, be it francophone, First Nation communities, rural communities, and then, program evaluation.

We currently have one geriatrician and have been lucky enough to recruit a care-of-the-elderly-based physician. We have an executive director/manager; clerical positions. We have an occupational therapist, physiotherapist, three nurses and a nurse practitioner who all help with this programming.

We service all of northeastern Ontario. We go from Parry Sound to the James Bay coast, with most recently having visited the James Bay coast to deliver geriatric care in conjunction with our partners, as well as with Dr. Sinha and Dr. McElhaney, to do our first visit for the elders in Fort Albany.

We deliver our care both by travelling around northeastern Ontario, as well as by telemedicine. Everyone who sees us has a comprehensive geriatric assessment done by one of our allied health care teams or by one of the local teams on the ground who we work in partnership with. They are then seen by the geriatrician or care-of-the-elderly physician, and then we work on treatment care plans.

One thing you will probably note is that there is no shortage of assessment for frail elders. We know how to assess them. Our job is not to assess them but to then identify how we can modify the modifiable, treat the treatable, and then bubble-wrap the rest, as I like to say. Our job is to work with the variety of organizations out there to actually intervene to reduce functional decline, to prevent frailty, to prevent unnecessary admissions to hospital and premature admissions to long-term care.

Our job is to make people live in their homes for as long as possible. That is not easy. It requires partnerships; it requires collaboration; it requires freedom of information; it requires sharing that information; it requires flexibility; it requires using the resources that you have in a flexible manner to identify their very unique needs. It involves working with caregivers; it involves finding caregivers when they have none.

It has, I have to say, been quite an experience since I've been in northeastern Ontario, because there has been no shortage of organizations or people willing to work in

that collaboration. I have seen us be enabled by the North East LHIN, by our CCAC partners and by our relationship with hospitals.

The barriers are a lack of consistent assessment tools, a lack of communication between providers, whether that's medical providers, community support systems, hospitals, our own program, physician groups. We all know what we want. We don't always know how to get it. We don't always know how to share it. An example is, we often, as physicians, will do a carpet-bomb approach to care, is what I like to say. You have a frail elder in front of you, so you refer to all these programs, whether it's community support services, my program, a psychiatry program, mental health. The elder will often go from having no one around to 17 assessments in the next two weeks—often the same assessment, often the same information gathered. In fact, I can guarantee you it is the same information gathered, just in a different tool. Mental health services will use the OCAN; CCAC will use the RAI; I'll do a comprehensive assessment; community support services will use a different version of the RAI—none of that information meets, and it's often the same information. So how we work together to integrate those assessments to create a single record that we can all work from and communicate is very important, I see, if we're going to care for frail elders, which is going to be an issue as we move on.

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What I have seen in terms of local solutions as well is the co-locating of CCAC case managers. In my own program, as well as in family health teams, caring for frail elders means we need to coordinate care. Oftentimes, the access to appropriate home care is a make-or-break solution as to whether people can live in their homes. That home care cannot be governed by rules necessarily, by tools necessarily. Oftentimes, there have to be unique assessments, unique considerations put in, and physicians need to be able to rely on the fact that that care plan that we put in is a reliable care plan. So access to reliable home care, to a coordinator whom we know we can talk with and communicate that care plan, who can modify the care plan based on ever-changing needs—and they can change quickly. A simple hospitalization, a simple fall, a simple change in medications can really change whatever is going on in that home from one minute to the next. How do we communicate with primary care? How do we communicate with hospitals? How do we communicate back to home care when these things change?

I have to tell you, the variety in home care services across northeastern Ontario is an ever-changing pattern as well. I know what I can get for a patient in Sudbury. I know what I can get for a patient in Parry Sound. I know what I can get for a patient in Timmins, but they're not always at all the same thing. We have one CCAC and one funding mechanism and one geriatric care, and it has nothing to do with anything other than human resources, often, or the ability to geographically deliver these services.

What I have seen is a willingness to discuss these issues, to meet with us, to work with us to deliver these services. I think that without a local flavour and a local appreciation for what the resources already are, that's next to impossible, especially for northeastern Ontario.

I'm not sure I have anything else to say. I'm more willing to talk about that, I think. What we've been able to accomplish: We've had almost 3,000 referrals to date since 2009. Since June of this year until now, we have done over 1,900 educational sessions. We have reached 1,900 providers since June of last year for capacity-building and education. I can't tell you what we've done every year in the last five years, but that's just since June of last year. We are an active program. We are actively reaching out to northeastern Ontario, to our care partners. We have a long way to go, but I don't think, for a region as geographically vast as northeastern Ontario, for a frail senior population who are incredibly unique, vulnerable—that cannot be done without a local solution.

The Chair (Mr. Ernie Hardeman): With that, we thank you very much for your presentation. The question will go to the opposition. Ms. Elliott.

Mrs. Christine Elliott: Yes. Thank you very much, Dr. Clarke, for your presentation. Congratulations on the success of your program so far. You indicated that there is a lack of consistent assessment tools, that different organizations require information presented in different formats. Is there a move afoot now to standardize the assessments into one standard assessment, or where does that stand at the present time?

Dr. Jo-Anne Clarke: I think the conversation is there; I'm not sure what the movement is. I think there are two issues. One is the assessment tool. So how do we choose these tools? Most of these tools are ministry-mandated, so CCAC uses one tool because this is what they're told to use. Seniors' mental health similarly use a different tool because that's what they're told to use. Clinicians use different tools. But we are all using the same—it's the same questions, just formatted differently. You're looking at talking with administrators, managers, health planners, physicians, hospitals, all of whom also don't like to share information because there are privacy issues. It's also an IT issue, so I think a lot of the information we gather could easily be shared if our EMRs connected, if our charts connected, if we simply charted.

I know there's an integration assessment record being created. I think that's a move to start to pool that information so that there would be a spot where all that information would lie. I think that's starting to happen, but I think what we need is better integration, because half the time, that assessor doesn't know that another assessor was there a week ago. That's what often—oh wait, I don't think I finished my thought on the carpet-bomb approach to referrals, which is that people will wait six months, 17 of us will go in, but as I walk in the door, they'll say, "Oh, Dr. Rivard was just here"—the geriatric psychiatrist—"yesterday," and I say, "Oh, shoot, you probably don't even need us anymore." CCAC just came

in, and all those things that we were worried about have been implemented now.

The problem is, we all have wait-lists as well. I bet you our wait-lists would be a lot shorter if we didn't all have to pre-assess and do these assessments. Secondly, if we knew that someone else was going in and we shared that information, the care plan might be a lot shorter and quicker.

Mrs. Christine Elliott: The EMR would be essential in helping you get to that point.

Dr. Jo-Anne Clarke: Yes.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come to talk to us today. Thank you.

TG INNERSELVES

The Chair (Mr. Ernie Hardeman): Our next presenter is TG InnerSelves: Rita O'Link, community relations, and Catherine Savarie, community facilitator.

Ms. Catherine Savarie: Thank you. Good afternoon. We are not an organization funded by the LHIN—

The Chair (Mr. Ernie Hardeman): Before we start—we haven't started your 15 minutes yet, but I should actually tell you about the 15 minutes.

Thank you very much for coming out today. You do have 15 minutes to make your presentation. If there's any time left, we'll have questions from caucus. With that, it's your 15 minutes to do with as you see fit.

Ms. Catherine Savarie: Thank you. As I had said earlier, we are not an organization that is currently funded—

The Chair (Mr. Ernie Hardeman): Since we have two making the presentation, could you introduce yourselves in the microphone for Hansard, for the record?

Ms. Catherine Savarie: I am Catherine Savarie and I am the community facilitator for TG InnerSelves.

Ms. Rita O'Link: My name is Rita O'Link. I'm the community relations person for TG InnerSelves.

The Chair (Mr. Ernie Hardeman): Thank you very much. Now your time has started.

Ms. Catherine Savarie: All right. The reason that we're here today is to bring a little bit of awareness around issues that face the transgender community, especially in the north. As I had said earlier, we are not an organization that is funded by the LHIN. Actually, we're not funded by any funding source whatsoever. We have just recently entered into dialogue with the North East LHIN, where they are consulting with our group with regard to the health care needs for the transgender community in northern Ontario.

The reason that TG InnerSelves was formed was due to the fact that we felt that we needed to have a transgender-specific organization to assist people who identify with that community and essentially help them navigate the system. One of them very much is the health care system, because it is a fairly complex health care

need, so the transitioning process is one that is fairly lengthy. Most people here in northern Ontario have to access services in southern Ontario for that transitioning process, and that can be very, very difficult. So we wanted to approach the LHINs with regard to having that dialogue around what it is that we're looking for in the north.

Rita had actually booked this presentation, so when we came here, we wanted to essentially bring awareness—we're not looking for funding—and sort of look at the objectives of the North East LHIN and see how they fit. So we have a very brief presentation for you.

When we did look at it, we realized that 11 of the 14 LHINs have made mention of looking at diverse populations. The transgender community definitely falls underneath that category based on gender, geographic location and socio-economic status. I do stress socio-economic status, especially for individuals who are transgendered in the north, because that is something that definitely affects the community.

When we looked at the first objective, we feel that for the most part, the North East LHIN has accomplished that for mainstream health services. We feel that this is a good opportunity for a path forward based on the already-existing foundation, because as we've entered into dialogue, we've seen that a lot of northern Ontarians who identify with being transgender are travelling outside of their geographic location to access services or the health care that they need.

1520

To identify and plan for health services: This is one objective that the North East LHIN, at this current time, has not accomplished for the transgender community as far as health care. There isn't a comprehensive plan, and it is very, very specific. That is one thing that most individuals who are transgender will vocalize: that they can't get that in their own northern communities. What our focus is with the LHIN here is to promote that path forward for the delivery of health services.

The third objective was to engage community persons—absolutely. Has the North East LHIN done that? Yes. We are currently in dialogue with them.

To ensure the appropriate processes: I think that as of right now, that objective has been fulfilled, and the LHIN has been very effective in providing the community with information on the appropriate processes and educating us a little bit about how they operate.

On objective 5, we do believe that the LHIN has been very effective in their ability to monitor and report on local health care service needs. But we do feel that new metrics have to be developed to measure success rates with the transgender health care services, because of the very secretive nature of being transgender, and that is what makes this community very unique.

Objective 6: We feel that they have definitely achieved this objective with the development of provincial strategic plans, which we have been made aware of, and with the implementation of systems tables, both local and regional. We are really looking forward to being able

to take our place at that table, to be able to participate fully as it moves forward.

For objective 7, we feel that, yes, they have achieved this objective, and they've built a very strong foundation to facilitate dialogue with an extremely diverse sector of the health care system.

Objective 8 definitely has been accomplished with the local health integration networks. We do feel that we do need access to high-quality health services for the transgender community. We know that it is a relatively new topic, so we want to utilize the framework with the LHIN to start establishing that.

As far as objective 9, with getting best practices and to promote knowledge transfer: Has the North East LHIN accomplished this objective? Yes. They have a very solid foundation to promote that. We believe once again here that there are new opportunities to be found in the north by expanding the role of the LHIN to work with front-line health providers. It's due to our geographic nature of the north that front-line health care workers take on additional duties in the delivery of health care that would be traditionally handled by other health care services.

For objective 10: Through recent discussions with the LHIN, it is the hope that health care services for the transgendered community will become more accessible, thereby increasing economic efficiencies within the health care system. Once again, we would like to utilize front-line health care service providers to be able to do this for the community.

Allocate funding: We feel that, through ongoing consultation with the LHIN, hopefully, funding will be allocated to the already existing health care services to provide health care services that are very specific to the community.

To enter into agreements: Once again, that is our hope, that they will be able to enter into agreements to provide the quality health care services that are needed very specifically for the northern trans community. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about eight and a half minutes left, so we start with the—

Interjection: The third party.

The Chair (Mr. Ernie Hardeman): That's what I thought. We start with the third party. Ms. Gélinas?

M^{me} France Gélinas: Always a pleasure to see you, Ms. O'Link, and a pleasure to meet you, Catherine.

Ms. Catherine Savarie: Thank you.

M^{me} France Gélinas: If you look at what you're trying to achieve, you're trying to have access to care in the northeast. If we take the first step, was the North East LHIN able to tell you who are the primary care providers who accept transgender people?

Ms. Rita O'Link: No. There is no information through the LHINs on who will provide us primary health care. One of the big things that we need is hormone replacement therapy. Very, very few physicians here in the north have any knowledge of that. They're

afraid to tackle it because they don't know, because there is no support.

Here's where we see opportunity with the LHIN structure: You are a network. We can utilize that network to get the information down to the front-line health care providers. They're the ones who can do it. We cover an immense geographic region. Travelling for any appointment is measured in terms of hours or days. If we can provide those services—and, by the way, they're not rocket science. They're well within the capability of a front-line physician. If we can get that information down to them—take care of it at home in the community, utilizing what is already there.

We don't have the population density to support centres. We're not looking for another bricks-and-mortar institution to say, "Okay. This is where you go." There's no reason why, through electronic means, all this cannot take place with the front-line health care provider in their communities. What we're hoping is, working with the LHINs, that that is where the money is going to be spent, and that is the direction we're going to go.

I'm a very conservative person fiscally. I want to get every mile per gallon I can out of a dollar. I don't want to see us building another institution; I want to see us make the ones that we have work efficiently, and we can do that.

M^{me} France Gélinas: Right now, would you say that there are areas within the northeast where transgender people are better served, or is it equally lousy no matter where you go?

Ms. Rita O'Link: As soon as you get north of Barrie, it's lousy. We're called a black hole up here, because, first of all, we're not supposed to exist, and second of all, if you want anything, the first thing the doctor does when he does manage to find it out is CAMH, and he sends you south. The waiting list just to go down there to meet with someone runs at something like six to eight months. Plus, now you've got the travel grants; you've got everything you've got to get in place. By the way, you've got to do that all on your own and you get reimbursed later.

The Chair (Mr. Ernie Hardeman): I'll have to stop you there, and we have to go to the government side. Mr. Colle?

Mr. Mike Colle: Thank you for coming. I think you're doing a good strategic thing by being here, because, as you said, you want to really introduce this need and make us aware of it and make the health service providers aware of it, too. So I think you're doing the right thing, really. You're taking a very good approach, because what you want to build, as someone said, is you want to build relationships.

Ms. Rita O'Link: Yes.

Mr. Mike Colle: And I think this is good. Have you had any discussion with anybody at the LHIN yet?

Ms. Rita O'Link: We've been very fortunate. We were invited by Mike O'Shea and his group to come and do a presentation for them. I'll say this about Mike—

Mr. Mike Colle: Who is that, by the way?

Ms. Rita O'Link: Mike O'Shea is the regional director here in the north.

Mr. Mike Colle: Okay.

Ms. Rita O'Link: He came to a presentation that we did in Sault Ste. Marie for the women's centre down there, because the Ontario human rights act was amended on June 19, 2012, to include gender identity and gender expression into the Ontario Human Rights Code. What we're trying to do is build the awareness that if we have those rights, then we need to come to the table and say, "Look, please, we need to be dealt with."

So we did that with Mike. Mike came to our presentations. He was very impressed. He asked us—and just this last week, we were able to meet with Mike here in Sudbury and his group, and give them a presentation on where we would like to go with things. So we're finally bringing this to the forefront. The co-operation with that group has been just marvellous. They're listening to us.

What we're coming to you for, and where I feel that you can really help, is we need to expand the role of the LHINs down to the front-line health care providers here in the north, because they are the ones who are there every day to take care of us. Until it's down to that level, it's going to be very difficult to service any of us.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for being here today. I also think you're taking a really commendable approach by being here, talking to us about what's going on. You're trying to work with the LHINs, and I think that's great. We certainly are cognizant of the changes to the Human Rights Code, and all three parties supported that, as you probably know.

1530

It sounds to me like there's some concern with the primary care providers here, just making sure that they are knowledgeable about what needs to be done, but I think there's also some transportation issues. I think you were getting to that with Ms. Gélinas's question. Could you maybe just expand a little bit about some of the challenges that you face there as well?

Ms. Catherine Savarie: This kind of goes back to something that is a little bit outside of health care: 75% of people who identify as being trans have a post-secondary education of some sort. Out of that 75%, a very large number only make about between \$7,000 to \$15,000 a year. You're looking at a population that is exceptionally marginalized.

When you are living in the north and you have to travel to CAMH in Toronto for a 15-minute appointment, that costs money. That is a huge issue, and not everybody can access the northern travel grant, nor do they even know that the northern travel grant exists. Then you're looking, once again, at upfront costs before you can be reimbursed. It is just not feasible.

We're seeing a large number of especially young people who identify as being trans, because that is actually becoming more and more prevalent. You're starting to see a lot of them move down south because

down south is utopia. It's not. That's why we have a 47% suicide rate in the trans community, because there is that inaccessibility to service.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this afternoon, and we very much appreciate you taking the time to come in and present to us.

Ms. Catherine Savarie: Thank you very much for having us.

NOOJMOWIN TEG HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Our next presentation is Noojmowin Teg Health Centre: Janet Fathers, registered nurse.

Ms. Janet Fathers: Thank you for inviting me. To start with, I'd like to introduce myself. My name is Janet Fathers and I am a registered nurse employed by Noojmowin Teg Health Centre. Any time you see two Os together in Ojibway, it's always pronounced "oh"—Noojmowin Teg, okay?

The Chair (Mr. Ernie Hardeman): Thank you.

Ms. Janet Fathers: You're welcome.

Noojmowin Teg Health Centre is an aboriginal help access centre on Manitoulin Island providing services to seven First Nations communities of Manitoulin and to off-reserve clients.

My program, the Aging at Home Program, is for First Nations elders, 55 and older. The Aging at Home Liaison position was an initiative of the LHINs about four or five years ago. The goal of the program is to keep elders safe and as healthy as possible in their own homes and out of hospital.

The job description included, "liaising between health care organizations for the best interest of our elders; working with current services providers, caregivers, family and clients in the community to build capacity; and teaching the personal support workers continuing education." The role was new and had to be developed. I was glad for my previous experience as a case manager with the CCAC, and as a head nurse in a long-term-care home.

The Aging at Home Liaison job description also said to "fill in the gaps," so I went out to the different First Nations communities and followed nurses and personal support workers around in their daily work to learn from them. As a result, I have seen gaps and have worked toward filling these gaps, one of which has been to attend both sites of Manitoulin Health Centre three mornings per week in a discharge planning liaison role. This is where the North East LHIN comes in.

Sometimes, funding is requested and provided, and guidance is needed to benefit most from it. I would hear, "They just give us money but don't tell us how to do it"—the program or the initiative. So I've been working alongside, mentoring the First Nations nurse care coordinators in their role, and with new initiatives, such as facilitating nurses in improved skill with negative-

pressure vac dressings; working toward a wound care protocol; working alongside staff with Heart and Stroke's Aboriginal Hypertension Management Program; mentoring each nurse in use the RAI assessment, the common assessment tool for use in community that you just heard about; and supporting the First Nation nurses as they gain confidence with intravenous therapy for long-term antibiotics in community. IV therapy in the community is a huge need. There have been many barriers to getting this program going, one of which has been funding challenges. The North East LHIN has provided funding for equipment and supplies for IV therapy.

Another goal has been to improve palliative care in the home for those who choose to die at home. We really want to focus on this this year.

Since I've been here four years, the North East LHIN has provided the mobile adult day program three days per week in three different communities on Manitoulin, two on-reserve and one off-reserve. The North East LHIN listened to our input when planning for this program.

They also listened when evaluating the assisted living program through VON for clients who need more hours of care daily than what our programs or CCAC can typically offer. One of the criteria for the assisted living program was that a client be within a 15-minute radius of the formal caregiver, the PSW, so that if the client had a fall, for example, the PSW could reach the client within a quick time frame. This 15 minutes may be reasonable if in the city, but Manitoulin Island is over 100 square miles, and there were many who desperately needed these hours of care but did not meet this criteria. So the LHIN really listened when that distance was extended to 30 minutes from 15 minutes, which, geographically, is much more possible here.

It was quickly apparent that we needed respite hours of care for caregivers of both palliative clients who needed 24-hour care and clients with dementia, who could not be left alone. The LHIN listened and provided funds for respite care over and above personal support hours of care for personal care. Now, for three years, when we've run out of funds for respite care, the North East LHIN has paid attention and has provided additional funding.

Noojmowin Teg Health Centre has an aging-at-home van, funded by the North East LHIN, which provides transportation for Manitoulin clients 55 and older to manage instrumental activities of daily living, such as getting groceries, banking and getting to medical appointments. This service, with the LHIN's permission, has been extended to non-First Nations, so it's used by both First Nation and non-First Nation clients 55 and up, mostly for medical trips to Sudbury, for example, to Health Sciences North. Again, this is used to its max, and the LHIN has provided additional funding at year's end, when requested.

For both of these programs, this year, a proposal was requested and approved in a very quick turnaround time, requiring only reasonable detail because of past and current well-documented need.

I've worked very closely with the First Nation care coordinators with complex cases, in family conferences and to assist as needed with advanced care planning and/or placement application to long-term care, short-stay or convalescent care programs. I made myself available, working along with and mentoring each nurse as she completes the CCAC's application package for the above programs.

Just recently, the North East LHIN has been quick to assist in problem-solving to facilitate a smooth transition from community or hospital to the above programs, both through collaborative meetings of all players and identifying challenges and working one-on-one to build capacity.

How is it that we are able to make ourselves be heard by the North East LHIN? We've had three LHIN representatives—outreach officers—since I started in this role. All three ladies have been accessible and approachable to us. They answer the phone, they take time to listen to our concerns and they attend our meetings, participating and providing helpful input and, again, hearing our concerns. The main meeting is the Manitoulin health links, where many health agencies of Manitoulin come together to network and share regarding common goals.

1540

Recently, the North East LHIN was hoping we would form a formal government health link or hub and work within its guidelines. When we voiced that we'd prefer to continue to work together as we have been, as what we've been doing has been working in our unique geographic, cultural and political situation, they listened again.

The RN care coordinators and I have attended annual events put on by the North East LHIN which have been a wealth of resources for our programs. The first, a day in Sudbury three years ago, was jam-packed with brief presentations of about eight new programs or initiatives funded by the North East LHIN, which are available to our clients. Without this, we might not have been aware or utilized these programs to their potential for the best interests of our clients.

All of these programs have been very helpful: for example, the Choices and Changes program, to empower clients to take responsibility and make changes in their lifestyle to benefit their health, and caregivers to make changes in their approach to clients, to maximize outcomes in their care; and the complex diabetes program in Sudbury, for the Sudbury/Manitoulin region, a wonderfully comprehensive program that many of our clients now attend—to name just a couple.

Other forums have been facilitated by the North East LHIN where we have come together to learn, to see how research aligns with real-life stories, to work on solutions to barriers and challenges, and to celebrate successes. Louise Paquette has been there, leading, her compassion and genuine concern evident.

The North East LHIN chose well in having Dr. Sinha, Ontario's senior care strategy lead, research and prepare his report *Living Longer, Living Well*. Again, we were

invited to sessions with Dr. Sinha, to share experiences from our everyday work with clients and to voice concerns. He and Louise Paquette go with teams to various areas, even to the most northerly regions, to listen to clients' concerns, and to the programs to see and hear first-hand what the needs are.

I think it's always a challenge to ensure that bureaucracy, the people at the top, really know and understand, and can make changes which impact in a good way the problems of clients and those working most closely with them at a ground-roots level, whether family caregivers, or formal caregivers such as PSWs, nurses, physiotherapists, social workers etc.

The LHIN does require reports from us in order to plan and validate our need for programs and funds. Yes, they need numbers, but I love that the North East LHIN is interested in our stories about real people:

—frail, elderly couples, one perhaps with a cognitive deficit, and the other with physical deficits, the two barely managing as one;

—grandmothers who are caring for grandchildren more than for their own health concerns;

—exhausted caregivers;

—perhaps a gentleman living in isolation, newly grieving the loss of his wife of 60 years; and

—everyday people whose conditions may be chronic and draining, or whose lives have been suddenly interrupted by disease or accident, with all the effects—physical, emotional, social, financial and spiritual; real people, beautiful people, trying their best, some needing more of our assistance, and others, with our support, empowered in self-help to be responsible for their own health and care.

I can honestly say that the North East LHIN has listened and heard. They've paid attention in a way that has impacted our programs and care, to make a difference where it really counts: in the lives of our clients. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about three and a half minutes, so it's just one, and it's the third party. Ms. Gélinas?

M^{me} France Gélinas: Well, there you go. I thought it was going to be your turn.

I appreciate you, very much, coming here today.

Ms. Janet Fathers: Thank you.

M^{me} France Gélinas: I'll start my questioning like I did with many others; I know you listened in on some of them. Right now, what would you say are the highest needs of the people you serve?

Ms. Janet Fathers: Well, I did mention in one line here that palliative care is very near and dear to my heart. People are choosing more and more to pass at home. That's what they want, regardless of culture, regardless of First Nation or non-First Nation. We need the human resources for that, we need the education for that, we need the capacity-building and, yes, we need funds for that as well.

M^{me} France G  linas: How do you see the LHINs being helpful in this versus what we had before, when you dealt with the regional office of the Ministry of Health? Well, you didn't, but somebody had before.

Ms. Janet Fathers: No. I can only speak from my experience in the last four years. I really, honestly feel that the LHINs do have their ear to the ground. They do listen. They are responding. When we say we have needs—I would expect that if we said, “We need more funding to develop palliative care programs to be better,” they would hear us and provide the funding.

Mr. Michael Mantha: Just a quick question on the home care front. Fifteen minutes would be great if that was possible, and for some people it is possible; 30 minutes would be great. But you know the area as well as I do. I know that there are PSWs who are travelling in from Gore Bay all the way in to Spanish to bring that care, and that's a lot more than 30 minutes; that's almost two and a half hours. Is that something that you see regularly in your area in the field of home care? What can we do with the LHINs to really change that?

Ms. Janet Fathers: First, let me say that in the programs that I work with, most of the First Nation health centres have their own PSWs. The five smaller First Nations have PSWs who work for all five through Mnaamodzawin Health Services. So we actually have pretty good PSW hours of care. Our problem is that we need more PSWs, more actual human beings, so that they're not burning out.

Our PSWs do get paid for travel. I believe that PSWs who work for places like Bayshore and Red Cross and VON need to have their mileage paid. The PSWs across the province, whether they're working in long-term care or community for aboriginal health centres, Red Cross or any other agency—I really believe they need to have standardized salaries. They need to get paid equitably.

What's happening in community care is—

The Chair (Mr. Ernie Hardeman): Thank you very much.

Ms. Janet Fathers: We're out?

The Chair (Mr. Ernie Hardeman): We have run out of time. We thank you very much for your presentation. Thank you for taking the time to come here.

Ms. Janet Fathers: Thank you.

PERRY AND PERRY ARCHITECTS INC.

The Chair (Mr. Ernie Hardeman): Our next presenter is Perry and Perry Architects Inc.: Jeff Perry, president. Thank you very much for your attendance today. You have 15 minutes to make your presentation. You can use any or all of that for your presentation. If you leave any extra time at the end, we'll have some questions and comments from the committee as they relate to your presentation.

With that, the 15 minutes are yours.

Mr. Jeff Perry: First of all, can you hear me? Am I close enough to this? Okay.

Thank you very much for affording me the opportunity to address the board and review committee. Allow me to introduce myself. My name is Jeff Perry. I am president of Perry and Perry Architects locally here in Sudbury and, as well, president of Perry and Perry Developments locally here in Sudbury, who have recently been actively involved in the development of seniors' housing.

Although we come with 26 years of experience within this community, we've done work throughout north-eastern Ontario and feel strongly that we can accurately reflect the needs as it comes to seniors' issues and, in particular, housing issues.

1550

Why am I here? I'm here basically to share our experiences and share an example of the relationship of the North East LHIN with respect to accessibility, collaboration, their partnering abilities, and the ability to address homegrown solutions and grassroots solutions in our community. We've had a very positive experience, and I'm also here to offer that perspective from the private sector.

But let me flash back a little bit—maybe a lot—at this point in time, back to 1944 in the city of Sudbury. Seventy years ago, post-World War II, the city is founded on a great base of nickel development and production. Things are booming and, of course, along with post-World War II, there are lots and lots of babies here. As we all know, and I'm sure we've heard many, many times before, this related population boom—of course, they're boomers—is in fact a strong influence in our community as well. In fact, during that time, between 1944—there was over a doubling of the population, approximately from 30,000 people to 90,000 people over a 10- to 15-year period. That's potentially 60,000 people who had to be addressed in terms of population growth. Their needs had to be addressed in terms of that population growth, including infrastructure requirements, schools, roads, retail requirements, of course housing requirements and, last but not least, their health care requirements.

The point to be made here is that at such time, those needs were built on the premise of a very young population—young in age, as I put it. As a result, those needs that had been addressed based on that young population were reflected accordingly in that development.

Now I'm going to fast-forward to today, which is 50 to 70 years later, and those babies that took place way back when are now that age: 50 to 70 years old. We, of course, are around this table today wondering how we can best address that, in particular the health care needs of that new society and that new reality. Over the most recent years, we've experienced a decade of change with respect to health care. We've invested in our hospitals. We've invested in our complex continuing cares. We've invested in our long-term cares. We are investing with a great deal of focus on our home care. We're also doing the math, we're counting the numbers, and we're coming

to the realization and determination that we basically can't afford it. We don't have the dollars, we don't have the capacity, and we don't have the workers. Our previous presenter already mentioned the fact that there are challenges with access to PSWs, nursing care, and, by simple demographics, we all know that there are fewer of the young ones and many more of the old ones.

Of course, we're all looking for alternative solutions. In particular, we're looking—in our case and in many cases across the province—for an ALC solution. Herein lies the challenge when we start to focus our efforts on home care. I divert back to the fact that in 1944, when this development was taking place in the city of Sudbury, there was the development of an infrastructure in the form of housing that took place that today houses those very seniors, in many cases. Although we've built complex continuing cares, long-term cares and enhanced our hospitals and have approached enhancement of our services for all, we still have a great deal of our aging population in inappropriate, small, high-maintenance houses in great need of repair, that we are trying to serve in the form of home care in an area of more than 3,200 square kilometres. So there are some obvious challenges with that, of course, in not only the practicality of being able to accomplish that but, as well, the reality of the costs of such service to be delivered to these areas.

With our efforts and with our collaboration and with our work with the stakeholders in the community, and in particular the North East LHIN, we've been able to focus on some opportunities that may result from a means of addressing this type of challenge.

Before you, I believe, there's a handout. I think everybody got one. In that handout is a very high-level reflection of what we have been working towards and what we have been evaluating with respect to what we call the affordability gap. As mentioned earlier, it's very difficult to afford, at \$850 a day, a bed at Health Sciences North. Complex continuing care services are approaching \$350 per day per bed; long-term-care costs are approaching \$130 per day per bed. We're comparing that with, as mentioned, the home care approach. As you can see, the image depicted at the far left is of a single-family dwelling: two storeys, stairs outside, big yard, long driveway and so on. The point is, in terms of home care, what we're trying to accomplish with the current infrastructure of housing form that exists in our society—and this is a Sudbury reflection, but I'm sure it's the same story across many communities across northern Ontario. We're finding it very difficult to serve those individuals in that inappropriate housing form.

What we've been exploring and investigating and even testing is the opportunity to look at filling that gap with an assisted living form of housing where a hub of assisted living services can be placed and formed at multiple-family-unit dwellings appropriate to the needs and access of seniors and frail seniors in our community.

The point to be made, and to keep it brief, is that without the collaboration, the co-operation, the interest and insight that is shared by all community partners but,

in particular, the North East LHIN, these types of projects, these types of stories and explorations, would not be feasible.

So I applaud the approach. I applaud the eagerness and the interest in working with all stakeholders, including the private sector, to look at opportunities to appease the challenges that we have in front of us with respect to seniors in our community.

With that, I'll leave it open for questions; I want to keep it brief. I'll leave you the floor.

The Chair (Mr. Ernie Hardeman): Yes, we have about six minutes, so we'll start with the government.

Ms. Helena Jaczek: Thank you very much for coming in. I think I probably speak for everyone on the committee: We're really enjoying some of the presentations made by the non-traditional health care providers, so thank you for this.

Maybe you could describe to us exactly—obviously, you've told us you're a builder and a developer and so on—how you have been involved with the LHIN. Did you voluntarily go to a LHIN board meeting? How did you become engaged in this whole issue?

Mr. Jeff Perry: Well, quite simply, I picked up the phone and contacted the LHIN in an effort to see if there's interest in this sort of thing, whether or not there are any synergies involved, and looking at opportunities to work together, whether it be simply by information dissemination or potential service funding for services for the elderly or some form of synergy that may make sense so that not only the LHIN but the seniors and all the stakeholders in the process of addressing this issue can all be successful in making that happen.

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Ms. Helena Jaczek: How have they engaged you subsequent to you picking up the phone?

Mr. Jeff Perry: Well, there have been several meetings, several interfaces, several discussions, several opportunities that have been explored, all resulting in a project that—in fact, there's an image of that very project in the middle, right above the affordability gap line there. That has, in fact, resulted in the development of an affordable housing for seniors' project. There are 32 units in that building. But as a private sector approaching that project on its own, it's not able to address all of the financial challenges that would keep it and make it affordable.

The Chair (Mr. Ernie Hardeman): I'll have to stop you there and go to the next question. Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Mr. Perry, and perhaps you could just carry on with your thought on that. I'm very interested in how you would see this operating and what the challenges are.

Mr. Jeff Perry: Well, long story short, in order to build that building in today's dollars, you'd have to charge a minimum \$1,500 a month for the unit that is developed. In partnership, in this case, with the Ministry of Housing and, in particular, the investment in affordable housing program, they offered capital to assist with

the overall capital cost of construction. As a result, we are able to offer the units at an agreed-upon affordable rate due to the influx of capital.

That's where it stopped, in terms of building bricks and mortar for affordable seniors. Therein lies the relationship with the North East LHIN, whereby the interest was to not only offer this to our seniors, but to supplement the bricks and mortar with a service within the four walls. So as a private sector, we couldn't afford it within the basis of an affordable scope. The opportunity is to have the LHIN—have those discussions, get the partners together and create the service environment that would allow and offer that service not only within that building, but as well to serve as a hub—

The Chair (Mr. Ernie Hardeman): We'll have to stop you again. The third party. Ms. Gélinas?

M^{me} France Gélinas: Sorry, just to follow on your train of thought, I'm becoming a little bit more picky in the answers as they go around. Is it better that the Ministry of Housing gives you capital up front so that you can offer a reasonable rent that you've agreed upon or the other model, where you have some units that go for market rents and the government subsidizes the people who cannot pay the full rent? What works better, in your thoughts?

Mr. Jeff Perry: From our perspective, it's six of one, half a dozen of the other. It's all about mathematics at that point. We know what it costs to build those four walls and that roof, and whether the money comes in the form of capital or whether it comes in the form of rent subsidy, it really doesn't matter. The results are the same; the affordability is available.

But the exciting piece of all of this is the collaboration and the joining of the community partners who have come to the same table and discussed this. I still think there's a long way to go, personally, from a private sector perspective. I think there are a lot of silos that have to come down. There has got to be a lot more synergy between those silos in terms of where the money comes from. I don't particularly care if it's from the Ministry of Housing or the Ministry of Health or if it's from some other ministry; it's all tax dollars. The net result is, hopefully, a better life for seniors.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. The time has expired. We do thank you very much for coming forward to make your presentation. I do have to say, it's one presentation that I haven't heard before in our travels so far. Thank you very much for bringing new information into the debate.

Mr. Jeff Perry: Thank you for having me.

MINE MILL LOCAL 598/UNIFOR

The Chair (Mr. Ernie Hardeman): Our next one is Mine Mill Local 598/Unifor, Anne Marie MacInnis, president. Thank you very much for being here, and we thank you for taking the time to come and talk to us. You have 15 minutes to make your presentation. You can use all or any of that time for your presentation. If there's

time left at the end of it, we'll have questions from the committee. With that, the floor is yours.

Ms. Anne Marie MacInnis: Thank you for the opportunity. Good afternoon, everyone. I'm here as the president, but I'm wearing my daughter cap today. I feel a little uncomfortable because I'm not one of the lobbyists here that are lobbying for the dollars, but I have to share my experience, and 10 years of it is going to be hard to complete in 15 minutes.

I just want to say that—a lot of things. In 2001, I lost my only child after going to a walk-in clinic four times and being told that I was overreacting and that he only had the flu. He dropped dead at home in a chair in front of my mom and I.

Then, in 2002, my father had his first heart attack. He went to the hospital and came home after that. He was still mobile, able to go out and socialize and able to bathe himself. He was still able to do all those things.

In 2004, he had another heart attack, and it was serious. What had happened was, at that time, he went into the hospital and he was allergic to a medication that they had given to him in the hospital. He was in restraints for two days—my background is in long-term care; I'm a PSW by trade, by career choice. What had happened then was, we went through the hospital system. He came home. Again, he had another bump in the road. He went back to the hospital, and it was very serious. He had developed many cognitive impairments and was losing bladder and bowel control.

Anyway, he was coming home again, so we knew that we had to have some help in the home. We knew that my mother was going to be the primary caregiver because I had to work. So we did have some folks come into the home. We were given a certain amount of time a day so they could bathe him. What had happened was, for three years, I slept on a couch because he was wandering at night and I needed to give my mother a break because she was deteriorating as well. So I slept on a couch so I could hear him. When he fell out of bed, I'd have to call my brother, my brother-in-law and family members to help me pick him up off the floor.

Then it increased again, and I was told that I only had so many hours in a day to have help to care for him to meet his basic needs. That meant, again, that my mother was the primary caregiver. When I got home, I took over. We all pitched in as a family because we loved my mom and dad. We loved them, so we did it.

Why didn't we place him in a nursing home, because I think at one point he could have been placed there? Because there's not enough time in a nursing home to care for a resident properly, and we knew that. Anyway, he went back into the hospital. He went through the rehab at CCC. He went back into the hospital again. He had to have a pig valve replacement. He made that decision with the doctor. I had asked to be involved in all those processes as a POA—he had a living will—and I was not.

In the hospital, he wasn't put on a toilet; he was told to go in a bedpan. There were all kinds of things that happened. He was a patient at the ALC for a while. He was

depressed at first, but then it picked up because he was given activities. They were involving him in things. He was actually enjoying it. I was able to go home and rest. It was nice.

In that time, though, my mother had died—at home; I found her on the floor. I took care of my dad for six months by myself. I couldn't do it anymore. I was told that I had four choices—I knew I didn't; I knew I could only choose one. I knew if I wanted to choose one, that's what I could do, but I knew that, right?

Anyway, we had him on a waiting list. I was told that if I paid for a private room he would be able to jump the queue. I didn't pay for a private room because it's about fairness and processes. I couldn't do that.

Then he was transferred back to the hospital because ALC closed—the Memorial site closed. He was brought back to the hospital. I had gotten a call 10 minutes before they were going to transport him in an ambulance. At this time, he's confused. He's scared. He doesn't know what's going on. I was told, "Well, you've got 10 minutes to get here." Guess what? I wasn't there and he was transferred.

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My dad ended up dying in the hospital on June 28, but before that happened, he had contracted C. diff. twice, he was in palliative care, taken out, then put back in palliative care because I demanded it. Even at the end—and I couldn't be at the hospital in ICU when my mom died because I was at home with my dad. I couldn't get help to be in there when my mom died. Everybody else was there; I wasn't. And I wasn't there when my dad died. Why? Because I was on the phone, dealing with the bureaucrats. I was getting hold of an advocate. I was calling Vale Hospice myself. I wanted him out of there to die with dignity and respect.

So, like I said, sorry. I really don't have anything positive at this time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. There's a lot more to a presentation like that when you're talking about how we're looking at improving our health care system than what you would—

Ms. Anne Marie MacInnis: There is.

The Chair (Mr. Ernie Hardeman): We very much appreciate you coming in and sharing that with us.

We do have some time—about eight minutes—left for comments, if there are any questions from caucus. We start with the PC Party. Ms. Elliott.

Mrs. Christine Elliott: First of all, thank you very much, Ms. MacInnis, for coming in today and presenting to us on such obviously deeply personal issues. All I can say is, I'm sorry that you've had such a terrible time with the system.

I'm just wondering if you've communicated those concerns to the LHIN. Have you spoken with them about the care that both of your parents received particularly?

Ms. Anne Marie MacInnis: As I said, on the last day, when my dad died, everybody was there but me because I was on the phone with the bureaucrats. I believe that you

try to work things out in the system, right? Truthfully, I was a little concerned because I saw that when I did say something, my dad would give me heck because he was treated differently. So when I did say something, I didn't want that to happen.

And the home care: I didn't even mention that. I kind of skipped over it, the missed appointments and people not coming out. At one point, we had to replace the bathroom because there was a flood in the bathroom. But that's okay; we put in the shower so he could get in and out more easily. But it's things like that. If there was a scheduling issue, my mother would have to contact the head office, which was in Thunder Bay. If we had somebody scheduled at 9 o'clock and we had plans for the afternoon to bring them out to enjoy life, we might have had to change them because they weren't going to be able to come in until a different time.

I want to say too that it was difficult, and I did see my mother deteriorate. She became depressed and anxious. That wasn't my mom. I can only imagine, to see your partner go through that and then know what's next—right? It was tough, but my God, she was a strong woman.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^{me} France Gélinas: Thank you for coming, Ms. MacInnis.

Ms. Anne Marie MacInnis: Thanks, France.

M^{me} France Gélinas: If you looked back at what your family went through and you had to change the number one thing, if you were able to change anything, what would be the one thing that you would like changed? I know there would be many, but what would be your top one?

Ms. Anne Marie MacInnis: I think I was fortunate, France, to work in a unionized facility so I could take leaves of absence. A lot of the time was spent—I went off work in May to care for my dad. I'm fortunate to be able to take that time off without fear of termination and things like that.

So probably—I almost feel like I'm owed some money. Maybe my mother was owed some money. Maybe for folks who are in their homes, and you have a primary caregiver who is a family member, look at some kind of compensation for that.

M^{me} France Gélinas: So when we have a willing family who's willing to take somebody back home who is very high care, consider paying the family rather than a home care agency to help? Or both?

Ms. Anne Marie MacInnis: Both.

M^{me} France Gélinas: Both.

Ms. Anne Marie MacInnis: Because it's 24-hour care.

M^{me} France Gélinas: Because it's 24 hours. Okay, so that's number one. Do you have a number two?

Ms. Anne Marie MacInnis: A number two would have to be, honestly, that it continue being a public system, that we be careful when we start venturing into P3s

with the private sector, because if you and I were going to get into a business, it's to make a profit.

M^{me} France Gélinas: And is this what you saw? Was this your experience, where the people coming to help were for-profit businesses?

Ms. Anne Marie MacInnis: Yes.

M^{me} France Gélinas: And you feel that this has an impact on the quality of care, the retention of workers and—

Ms. Anne Marie MacInnis: Certainly, because there's no money left to pay the workers and other forms of pay—because, I mean, it's to make a profit. Somebody has to pay for it, and it's usually on the backs of the workers.

M^{me} France Gélinas: Do you know how much the PSWs that were coming to help your parents were making?

Ms. Anne Marie MacInnis: Yes, they were making a little over \$13 an hour before they organized.

M^{me} France Gélinas: Has it gotten better since they were organized?

Ms. Anne Marie MacInnis: Not with the recent award. Long-term-care workers—we're on a freeze, right? People are asked to not get a raise for five years now.

M^{me} France Gélinas: That's a long time.

Ms. Anne Marie MacInnis: It's a long time, a very long time. And no COLA or things like that.

The Chair (Mr. Ernie Hardeman): Thank you very much. The government: Mr. Fraser.

Mr. John Fraser: Thank you very much, Ms. MacInnis, for sharing your family's story. In our family, we're currently going through the same thing. We've been doing some couch-sleeping for about three or four months. I can't imagine doing it for three years.

Ms. Anne Marie MacInnis: Ten.

Mr. John Fraser: What's that?

Ms. Anne Marie MacInnis: Ten.

Mr. John Fraser: You did it for 10 years. I can't imagine doing that. That's a lot of sleeping on the couch and not always sleeping well.

I'd like to go further to Ms. Gélinas's line of questioning, but I'd like you to be a bit more specific in terms of your personal circumstance as to how the care could have connected to you better. You said that in the last day, you were trying to organize—you were going to the hospice yourself. So do you have any thoughts, comments or something that would have made it better in your situation?

Ms. Anne Marie MacInnis: I do. I know recently I've asked a couple of folks who are in the RN program, "What do you want to do?" And their comment is, "To be a boss." So I think that what's happening is that there's a lot of money that's being spent, and it's going to top management, and it's not trickling down.

We all want to work. We all have to work, right? But I think that there has to be, as the doctor had said before, some kind of coordination. There has to be standardization. There have to be those things so people aren't jumping through the hoops to get the care that they need.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you coming out and sharing that with us.

That, as I look on my list, was the last delegation. If there is no further business for the committee, the committee—

Interjection.

The Chair (Mr. Ernie Hardeman): We'll be leaving—in the lobby—at 4:40 p.m.

With that, thank you all for your attendance. I thank the audience for their attendance.

We have a hand up.

M^{me} France Gélinas: It's very mundane. I have to drive to the airport, so whoever wants a ride with me, you can save a cab and hop on.

The Chair (Mr. Ernie Hardeman): This committee stands adjourned until tomorrow morning at 9 o'clock in Thunder Bay.

The committee adjourned at 1619.

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Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Wednesday 5 February 2014

Journal des débats (Hansard)

Mercredi 5 février 2014

Standing Committee on Social Policy

Local Health System Integration
Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Wednesday 5 February 2014

Mercredi 5 février 2014

The committee met at 0905 in the Valhalla Inn, Thunder Bay.

LOCAL HEALTH SYSTEM INTEGRATION
ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. We'll start the meeting. We thank everybody for coming to the Standing Committee on Social Policy meeting of February 5. We're here for the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act. We're doing the public consultation, and we're happy to be in Thunder Bay this morning to hear presentations.

NORTH WEST COMMUNITY CARE
ACCESS CENTRE (THUNDER BAY)

The Chair (Mr. Ernie Hardeman): Our first presentation is the North West Community Care Access Centre of Thunder Bay: Rob Stinchcombe, chair; Brad Coslett, vice-chair; and Tuija Puiras, chief executive officer. Thank you all very much. I just want to point out, first of all, that I have trouble pronouncing my own name, so I have real problems with others, but the Hansard will copy them all perfectly. The record will show the right way.

Thank you very much for being here. As we've been doing around the province, we do have 15-minute presentations. You'll have 15 minutes for your presentation. You can use it any way you like, any or all of the time. If there's extra time, we'll have questions from the committee to your presentation. If not, you can use it all yourself. Your 15 minutes starts right now.

Mr. Rob Stinchcombe: Right now? You can hear me? You can hear me, I'm hoping.

We picked our presenters because of the difficulty of their names for pronunciation purposes.

Good morning, Mr. Chair and members of the Standing Committee on Social Policy. The North West Community Care Access Centre appreciates the opportunity to present to you today as you continue your review of the Local Health System Integration Act.

My name is Rob Stinchcombe. I'm the chair of the board of the North West Community Care Access Centre. I'm here today with my colleagues Brad Coslett, our vice-chair, and Tuija Puiras, our chief executive officer.

I'll be doing most of the presentation today, and then Brad will be joining in. Tuija is here to make sure that we don't say anything out of line.

Ms. Tuija Puiras: I can answer questions.

Mr. Rob Stinchcombe: The North West Community Care Access Centre is a health care service provider as defined by the LHIN legislation, and we're accountable to the North West LHIN through our service accountability agreement.

Each year, we provide over 13,000 people with the care they need at home, at school and in the community. In total, the North West Community Care Access Centre covers a geography of 460,000 square kilometres, approximately 47% of the land mass of Ontario. The northwest region has approximately 230,000 people, including significant aboriginal and francophone populations. This large land mass, with a population density of one half of a person per square kilometre, makes the delivery of high-quality, cost-effective home care and community care pretty challenging. To provide this service, we have 14 locations throughout the region, and our care coordinators can be found in any of the 13 hospitals, and doctors' offices, schools and other community agencies.

Fortunately, the North West LHIN understands the regional challenges we face and promotes robust, collaborative partnerships and assists in facilitating finding better ways to serve the people throughout the northwest.

Community and home-based care continue to grow in importance as we look to meet the changing needs of the people in our communities. We're continually faced with significant and growing challenges to ensure that we can provide high-quality health care and prepare for future demands.

The North West CCAC believes that the LHIN legislation review is a great opportunity to further strengthen the current system and promote optimal health and well-being for everyone.

Our provincial association will be providing a broader perspective in its submission to the standing committee. However, in our time today, we would like to focus on how we work with the North West LHIN in relation to the current framework for local health system planning, funding and accountability, and provide some recommendations for improving the current framework.

The North West CCAC works directly with people so they can live and age safely in their own homes and

return home after a stay in hospital. Basically, what we do is help people.

Here are a few of the ways we helped people last year: Our employees helped about 4,700 people to return home after a hospital stay. Our employees completed approximately 10,800 visits with people to talk about what services they need so they can be as independent as possible. On any given day last year, there were 4,680 people receiving services from the North West CCAC. Our employees helped 637 people access a long-term-care home. Our employees helped 1,819 children by setting up services such as speech therapy so they can go to school every day. Our employees connected 949 people to a primary care provider through the Care Connector program.

In addition, our care coordinators are health professionals who work hand in hand with people and their families to develop a care plan that is right for them whether it is nursing care, meal delivery, a day program or help finding a family doctor.

Care is delivered at the right time through efficient care coordination practices that allow for timely identification and timely provision of needed services. The people we serve and our health sector partners continue to tell us that we are doing an excellent job.

The LHIN legislation requires LHINs and health service providers to engage their partners and the public. In our experience, the North West LHIN undertakes extensive community engagement to inform, educate and empower stakeholders in planning, decision-making and improving the experience and outcome of the patient experience.

The North West LHIN carries out local system level planning and funding as it relates to the needs of the community. It guides integration initiatives with health service providers while respecting the experience of the stakeholders. The recent Telehomecare initiative is one example of many where the North West LHIN focused on the expected outcomes and left the implementation of the program to the partners. The Telehomecare program assists people with heart failure, COPD and other chronic conditions, and augments the care people receive from their primary health care providers. It also allows people to stay in their homes longer and eases the pressure on the local health system.

The North West LHIN recognizes that every model of health care cannot apply to every community, and instead carries out local system level planning, resulting in the region's Health Services Blueprint containing 44 recommendations for ways of reducing demand for hospital services, lowering the number of emergency department visits, and improving access to care and delivery of services in our various communities.

The North West LHIN Health Services Blueprint is based on the integrated health services model, and will ensure services will be organized at three levels within the LHIN: the local, district and regional.

The health system model will bring decision-making and accountability closer to the community level to im-

prove the patient experience and make the system more sustainable. An example of how this is working is the myCare program. This unique pilot was the first of its kind in Ontario, and studied the possibility of meeting the needs of residents with local nursing resources that would be funded by the North West CCAC, hosted by the Manitouwadge hospital and managed by the family health team. The program is successful and plays a significant role in helping more patients live safely at home, especially in small and rural communities.

MyCare is also a great example of how the current system works by building on the solid foundation provided by the LHINs and the LHIN legislation, and by constantly keeping the patient at the centre of the care plan.

We would like to suggest one area for improvement in the legislation. A well-designed system is one that promotes strong partnerships, a shared vision and effectively supports patient care. Funding stability and predictability have significant impacts on the consistency and quality of care for patients in the home and the community system. As a paradigm for progress for the delivery of care in the community, we believe there is a need for the ministry, the LHINs and health service providers to consider opportunities to improve the funding allocation process. Inequity in funding levels and in funding enhancements across regions can create challenges in providing equitable access to consistent levels of care. The confirmation of funding allocations varies with health service providers and uncertain allocations create fluctuations in the delivery of care, thereby creating confusion and compromising the confidence of our patients, families and our health care partners in our services and in the system overall. Some form of multi-year funding would create more stability in our service-level planning and provide more predictable service-level patterns.

0910

Overall, the Local Health System Integration Act provides a well-structured foundation and the ability for the North West LHIN to promote community engagement, allocate funding and require accountability, as well as carry out local, regional and district-wide planning. The current legislation supports the North West LHIN in its work with its partner organizations at the board level, the leadership level and at the front-line level to find new ways to better serve the regional population's health care needs.

Brad?

Mr. Brad Coslett: Building a stronger, higher-quality health care system requires effective integration throughout the health system. Getting there involves community engagement. The current legislation allows the LHINs the ability to lead through community engagement funding and planning, where all stakeholders understand the vision and priorities for change and build the system through mutual accountability across the care continuum. The current system does work, but we know we can do better.

Community and integrated primary health care focus will provide opportunity for chronic disease management and build a system that is geared to support healthy aging. Health links is a critical piece in the transformation of health care throughout the province and, more importantly, throughout the defined geographical areas where all health care providers can work together to improve access to care and provide better value and higher-quality care for those who need it most. Development of the long-term capacity plan is needed for each LHIN and the correct balance will detach any schisms to ensure the right services exist across the continuum of care to meet current and future needs.

Mechanisms to improve the predictability of funding over multiple years will assist in meeting those needs by enabling better service-level planning. The milestones reached with the current structure are significant within our communities for moving forward in meeting our future needs. Ultimately, regardless of structure, a common vision focused on the people we serve and strong, collaborative relationships are the key ingredients to making the health care system work. With our LHIN and our health care partners, we know we can continue to create an improved system and provide better care to the people of northwestern Ontario.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes left, so we'll have questions from the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for coming in. You've probably heard—this is day six of hearings—that there have been some suggestions that perhaps the CCAC could be folded into the LHIN and that the LHIN could, in fact, contract service providers directly for the purposes of home care and all the other activities that the CCAC currently engages in. What comments do you have about that suggestion?

Mr. Rob Stinchcombe: Maybe Tuija would like to add to what I have to say. Right now, there are two distinct functions. The LHIN obviously has a planning function, allocates funding to various organizations and requires accountability for the use of those funds. What we do as a CCAC is direct delivery of service, care co-ordination, and it's quite a distinct function to what the LHIN provides. I'm not sure that the LHIN would be in a position to provide the kind of service that we do. Based on my experience in my working career, I think the differentiation between the funder and the service provider makes a lot of sense.

Tuija?

Ms. Tuija Puiras: Just to add, I think there is quite a bit of work happening with the evaluation of the services, and there are opportunities to look at integration more on a horizontal level, like community support service organizations, mental health organizations and so on, where efficiencies can be better accomplished.

Ms. Helena Jaczek: In other words, rather than reduce administration within the CCAC, you're talking about efficiencies amongst other health care—

Ms. Tuija Puiras: Virtual integration, as we have started with many of the service providers, where we are concentrating more on the actual service provision and making sure that there is better integration and seamless flow from setting to setting.

I will remind you also that we did merge already from 43 community care access centres in 2007 to 14.

Ms. Helena Jaczek: Okay, thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come and talk to us this morning.

Mr. Rob Stinchcombe: Thank you.

NORTH WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the North West Local Health Integration Network: Laura Kokocinski, chief executive officer, and Reg Jones, board member. Thank you very much for taking the time to come and talk to us this morning. As with the previous delegation, you will have 15 minutes to use as you see fit. You can use any or all of that time. If there's time left over, we'll have some questions and comments from our committee.

The floor is all yours for the next 15 minutes. Thank you.

Ms. Laura Kokocinski: Good morning, Chair and honourable members of the standing committee. My name is Laura Kokocinski, and I'm the chief executive officer of the North West Local Health Integration Network. With me here today is Reg Jones, the secretary-treasurer of the North West LHIN's board of directors.

I would like to thank you for the opportunity to speak with you today as we review the Local Health System Integration Act. I have read through the Hansard transcripts, and the comments and questions being asked show your strong commitment to the health care needs of the people of Ontario and the sustainability of our health care system.

I am also aware that you have already received the LHIN's four recommendations about the legislation. As a result, my plan today is to focus on our local story: the North West LHIN's performance as it relates to the mandate given through the Local Health System Integration Act of 2006, and why local planning, funding, performance management and accountability are essential to these successes.

The North West LHIN has the largest geography of all the LHINs, with approximately 47% of Ontario's land mass and 2% of Ontario's total population, with nearly two thirds of our region having no road access. We, along with our 93 diverse LHIN-funded health service providers, face unique challenges in planning, funding and integrating health care services to ensure a healthier population and a strong, sustainable health care system

and service to all residents of northwestern Ontario. In fact, over 93% of hospital-based health care services for the people of northwestern Ontario are provided right here within our LHIN.

Health care system planning is complex. Over the years, we have heard from our health service provider partners the need for a common vision, something that brings the health system transformation into focus for northwestern Ontario. As a result, in 2010, the North West LHIN began a process of extensive consultation, community engagement, collaboration, and research to build a framework to guide the work of the LHIN and its stakeholders, culminating in the North West LHIN's Health Services Blueprint. I've provided a summary document in your package today for your information.

This blueprint is a customized, multi-year integration strategy made in northwestern Ontario, for the people of northwestern Ontario, that will improve population health, access to care, quality of care, and sustainability.

There continues to be significant engagement as we advance the blueprint, and I'm very proud to report that champions for change are taking on the leadership roles necessary for system transformation in our region, and you will hear from some of them today.

The LHINs have the legislated ability to bring health service providers together to implement innovative and effective local solutions that meet the unique needs of each community. Convening providers around the same table through a collaborative governance approach has been a critical step as we create a common vision to achieve a system that is population-based and person-centred. For example, we have reduced unscheduled repeat emergency department visits for substance abuse and mental health conditions through a program called GAPPS—Getting Appropriate Personal and Professional Supports.

0920

The GAPPS program began six years ago when the North West LHIN issued a call for proposals to reduce emergency department visits. Three separate providers submitted similar proposals. The North West LHIN met with the providers and asked, "What could you do if you worked together?" The result was the GAPPS program, built to respond to the unmet needs of a marginalized population of vulnerable persons with serious, unstable and complex mental health and addiction issues. For example, an individual we will call John visited the emergency department more than 88 times in a year, with 11 hospital admissions totalling 107 days.

Working with GAPPS, John was connected with permanent housing and the right care to stabilize his conditions. Because GAPPS helped John navigate the system to find the right care in the right place, he no longer visits the emergency department, nor has he been admitted to hospital in over a year.

Access to care can take on many forms. The North West LHIN eHealth strategy is one way we are improving access to care. Stemming from local planning and collaboration, as already noted, all 13 hospitals in our

region share a common health information system. Almost 72% of primary care practitioners have implemented electronic medical records, and the vast majority of those have adopted a physician office integration approach, which allows them to securely receive patient data electronically, directly from any hospital in the North West LHIN.

I could talk about the financial and the health human resource benefits that are realized through this shared platform, but instead, I will speak to the impact on patients and their families. For example, imagine that Mr. Smith has been brought to the emergency department at the Lake of the Woods District Hospital in Kenora near the Manitoba border and needs to be transferred to Thunder Bay Regional Health Sciences Centre for acute care. Lab tests were started in Kenora, but the results were not available at the time of his transfer. By the time Mr. Smith reaches Thunder Bay, his medical information, including those lab results, will already be with the attending physician.

Seamless, person-centred care, care in the right place in the right time by the right provider, almost 500 kilometres from home: This is system integration at its best.

The LHIN continues to explore options to improve access to care. Through extensive community engagement, the people of northwestern Ontario, particularly seniors, tell us that it is important that they receive care closer to home. That is why over the past four years the North West LHIN has invested more than \$18.8 million in the community sector, increasing access to home care, community support services, assisted living, supportive housing, community respite and primary care services.

In addition, telemedicine is widely used in our region, giving residents and health care providers the ability to consult with specialists thousands of kilometres away. Through LHIN funding, telemedicine clinical visits nearly doubled between 2010 and 2013, and the North West LHIN continues to be the second-highest user of the Ontario Telemedicine Network. Recent investments in a new Telehomecare program will support and monitor 300 people per year newly diagnosed with congestive heart failure and chronic obstructive pulmonary disease. They will learn to manage their condition, and emergency room visits will be reduced in the first year by over 20%.

With a sparse population dispersed over a vast geography, we know that mobile solutions also work very well for our region. For example, a made-in-the-north solution is the diabetes mobile unit, funded by the North West LHIN, which visits nine communities on a regular basis to provide primary care services such as eye care, foot care and diabetes monitoring, diverting people from emergency departments and improving the quality of care through better chronic disease management closer to home.

Even with these investments, access to care continues to be challenging for patients and their families in northwestern Ontario, and we know there is still more work to

be done. The LHIN legislation lays out an accountability framework, and the North West LHIN board of directors has developed a policy whereby the North West LHIN investments achieve desired outcomes and demonstrate value. Through our service accountability agreements, we are measuring health care performance, setting targets and holding health service providers accountable for achieving specific results and outcomes.

I'd like to illustrate how the North West LHIN demonstrates value for money. We recognized early on that chronic disease self-management was emerging as a leading practice in improving patient outcomes. In 2008, the North West LHIN implemented the chronic disease self-management train-the-trainer program. By 2009, more than 75 master trainers were positioned across the region, including as far north as Fort Hope, our northernmost community, on the shores of Hudson Bay. In 2010, the self-management program was transitioned to a health service provider that continues to operate the program today, with more than 300 people receiving self-management training and support each year through the region to manage their own chronic conditions.

The chronic disease self-management program gained provincial recognition and, last year, became a provincially funded program. We know this model works, and it works very well in our region. We are now embarking on a new self-management program that will focus on foot care, to reduce the number of amputations, decrease the number of hospitalizations and improve health outcomes for people living with diabetes across our region.

Over the past eight years, the LHIN has seen several voluntary integration initiatives that have resulted in reduced duplication, overall cost savings, and enhanced access to services: better value for health care dollars spent.

Last month, four providers shared two integration stories with their peers at the North West LHIN's biannual governance-to-governance session. The first integration saw a reduction in duplication when an Alzheimer's day program merged with a local supportive housing organization. In the second, a consumer-driven mental health agency amalgamated with a larger mental health organization. Successes were nearly identical. Duplication was reduced, and realized savings were reinvested into expanded patient care services.

The North West LHIN continues to work with its providers and stakeholders to look for innovative approaches that are cost-effective and evidence-based, in service to the people of northwestern Ontario. As regional planners, the North West LHIN recognizes that effective population health planning involves understanding the needs of patients, communities and the sub-populations that reside in our region, and the LHIN is well positioned to address these needs through the legislation, with decision-making at the local level.

I've told you about our geography. Now I'd like to talk about the people.

We know that residents of northwestern Ontario are among the most active in the province and have a strong

sense of community belonging. However, we also have a high burden of illness and high rates of hospitalization and emergency department visits, particularly for diabetes, mental health and substance abuse, chronic obstructive pulmonary disease and heart disease.

The North West LHIN also has the largest population of aboriginal persons in Ontario, at almost 20% of our total population, and we fund 44 organizations to provide appropriate care in communities. Additionally, 3% of the population of northwestern Ontario is francophone. The North West LHIN understands that health care needs differ from community to community, and that it is important to provide culturally safe health care services for diverse populations.

The North West LHIN has a number of processes in place to ensure that these populations are actively engaged in health care planning, and they help to inform the LHIN's work. Many of these processes are outlined in the annual report, which we have included in your package today. Additionally, to address equity, in 2013 the North West LHIN added a diversity indicator to the health service provider service accountability agreements, and the subsequent reports will assist future planning in this area.

As you have heard, the North West LHIN has embraced the legislation and is working with communities, as well as funded and non-funded health care partners, to address the health care needs of the people of this region.

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Thank you very much for the opportunity to present to you today. Reg and I would be very pleased to answer any questions you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half left. It will be the official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation this morning. We really appreciate you coming to address us. I'm particularly interested in the way that you engage different populations. I know you've told us that they're in the report. We've heard from some First Nations groups that they don't feel that they are adequately involved in planning and consultation, not necessarily in this LHIN, but I'm wondering if you could tell us how you engage particularly First Nations and francophone communities.

Ms. Laura Kokocinski: I'll start with talking about the initial strategies that we put in place to engage our aboriginal communities and the populations. Back in 2008, we held our very first Aboriginal Health Forum right here in the city of Thunder Bay. We had well over 300 aboriginal communities, health directors, chiefs and councils that attended that, from Inuit, Métis, on-reserve and off-reserve individuals, to talk about health care.

What we were told at the time—this was the first time that that group of people had ever been together to begin to have a dialogue and a discussion about health care. Certainly, part of that forum was to talk about the process

in Ontario and what is happening with health care in Ontario.

Since that time, we've held two other Aboriginal Health Forums. Following that third forum, it was agreed that we would continue to work with the health directors. So we have 69 health directors that we meet with twice a year. We actually fund some of their travel. Due to some of the funding issues on-reserve, it's very difficult for people to get together. We also use telecommunication and videoconferencing to link people together to talk about what the needs of health care are.

In addition, as we're doing our integrated health services plan every three years, we have surveys that we also use and engage that population in discussion and dialogue.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your participation this morning. We very much appreciate it.

Ms. Laura Kokocinski: Thank you so much.

OPSEU, MENTAL HEALTH DIVISION AND HEALTH CARE DIVISIONAL COUNCIL

The Chair (Mr. Ernie Hardeman): Our next presenter is OPSEU, mental health division and Health Care Divisional Council: Ed Arvelin, registered practical nurse.

Thank you very much for coming in this morning. We very much appreciate your participation. You will have 15 minutes in which to make your presentation. You can use any or all of that time in that presentation. If there's any time left over, we'll have questions and comments from our committee members. With that, the next 15 minutes are yours.

Mr. Ed Arvelin: Thank you and good morning. With me today is Carl Thibodeau. He's an executive board member through OPSEU and part of our region 7 here.

My name is Ed Arvelin. I'm the Chair of OPSEU Health Care Divisional Council, which represents approximately 47,000 professionals and support staff in Ontario's public health system.

In 2010, the Ombudsman expressed concern about the level of public engagement by the local health integration networks. In *The LHIN Spin*, André Marin summarized what many of us were led to believe the LHINs would be about:

"Citizens, health service providers and other stakeholders were repeatedly told by government representatives that under the LHIN system, they would have a voice in the health services decisions that affected them. The public was assured that with the advent of the LHINs, an aloof, centralized bureaucracy would no longer be making significant decisions about the future of community health services. Instead, decisions would be informed by local needs and priorities, and made in and by the community for the community."

This contrasts greatly with what the LHINs themselves have had to say. Matt Anderson, a former CEO of

the Toronto Central LHIN, speaking at a Longwoods forum in Toronto in February 2010, six months prior to the Ombudsman's report, was blunt about where the LHIN priorities came from. He told the forum: "If they"—the elected officials—"say these are the priorities that the people of Ontario wish for, these are the priorities."

Globe and Mail columnist Adam Radwanski questioned how Anderson, a rising star in the health system, could leave the most powerful LHIN in the province to eventually assume the helm of three suburban hospitals—Anderson is now the CEO of the William Osler Health System. The answer is simple: There is no real or substantial power at the LHINs. They are, by legislation, an extension of the Ministry of Health. We closed seven regional offices to open 14 in their place.

During the same speech, Anderson indicated that despite a budget of \$4.2 billion, the real discretionary fund of the Toronto Central LHIN was approximately \$10 million to \$12 million. The reality of the LHINs has always been at odds with the vision that was initially sold to us and outlined by the Ombudsman.

Despite being weakened by the closure of regional offices and significant reductions in staff, the Ministry of Health and Long-Term Care still maintains all the real power, leaving the LHINs to essentially tinker around the edges and to take the blame when unpopular decisions are made.

Back in 2006, we warned that the LHINs would be used to deflect criticism around rationalization of our health care system. The examples of this are many. When the Globe and Mail reported on the closure of ERs in Fort Erie and Port Colborne, journalist Karen Howlett wrote in 2010: "Ontario Premier Dalton McGuinty is distancing his government from the controversial closing of emergency departments in two hospitals, saying it was a provincially appointed health agency that made the decision."

Cobourg's Dr. Alex Hukowich was an original member of the Central East LHIN board to 2010. In his departing speech to his fellow board members, Hukowich lectured his colleagues, concerned that quality indicators got less attention than financial accountability. He also emphasized the difference between accessibility and availability, particularly as it applied to such delisted OHIP services as physiotherapy.

At the end of his farewell, he presented the LHIN chair with a game he had invented that he said would help with decision-making. The game consisted of coloured playing pieces and a black box. Green pieces represented funded parts of the health system that were valuable, red pieces represented funded parts of the system of little or no value, white pieces represented new initiatives that would be good for the system, whereas yellow pieces represented new projects from special interests that were of little use.

The objective was to pick out the red pieces from the box while leaving the green pieces in. You had to do this while your opponent tried to toss in white and yellow

pieces. There was one other criterion: The player had to pick out the red pieces and deflect the yellow pieces blindfolded.

After four years on the Central East LHIN board, it was a frank admission that the good doctor had no idea whether they were contributing to the benefit of the health system.

At times, the board seemed to openly question whether the changes they made to solve one problem didn't inadvertently create new problems. Our health system is clearly interdependent and yet the big picture seems to be continually absent from specific integration decisions. After seven years of local health integration networks, we still really don't know the answer to Hukowich's question.

It's not like there haven't been good initiatives. Having an organization bring together varied community health providers has merit, especially if we want to move away from silo thinking. Health links, for example, appear to have promise even if it is too early to assess the results. One Toronto community mental health provider told us that at one time the dozens of agencies in the city had no idea who was providing similar or complementary services. That has changed under the LHINs.

The emphasis on financial accountability appears to have made a difference in reducing the number of hospitals running operational deficits. Like Dr. Hukowich, we would have liked to see a more balanced approach to the quality indicators, given these deficits were often fought at the cost of access to clinical services.

Having the LHINs in place has also given us an opportunity to intervene on planned closures and ask pertinent questions around service transfers, including whether adequate human resources have been put in place. We have also seen LHINs reallocate services and find new providers when an agency simply decides to close their doors. When Toronto hospice Perram House gave little notice of closure, it was the LHIN that was able to find last-minute alternate arrangements for the remaining palliative clients at the hospice.

One of the biggest difficulties for us was the realization that despite the broad definition of "integration" in the Local Health Service Integration Act, this did not mean that all of these integrations would be subject to detailed public disclosure or, often, an opportunity for public input in the decision-making.

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For example, the Ottawa Hospital decided last year to divest 4,000 endoscopies to the community. The LHIN decided that it did not constitute an integration because the hospital was merely following an accountability agreement. Clearly, the LHIN was willing to let the hospital shed any services it chose in order to balance its budget. This, we believe, is completely irresponsible.

Similarly, in 2008, when the Rouge Valley Health System decided to transfer acute mental health beds from Ajax-Pickering hospital and consolidate them with the Scarborough Centenary hospital, it was never treated as

an integration decision. In fact, discussions between the LHINs and the hospital on the decision were not only withheld from the public but also from the LHINs' own working group on mental health.

When we unsuccessfully challenged the absence of public input at a judicial review, the LHIN made it clear that, given the transfer was taking place between the two sites of the same hospital corporation, it technically didn't constitute an integration. There was no shame in the fact that the public was completely shut out of this decision that impacted many families in the west Durham community.

At the time, the Ajax-Pickering hospital was undergoing a significant capital expansion that included a state-of-the-art mental health facility. The mental health unit was completed; it was never used. Evidently, to save money for the hospital's operating budget, the LHIN was more than willing to squander significant capital expenditures on the new facility.

While it would be simple to add up the failures of the LHINs and return to a central ministry-driven system from Toronto, we believe that this would be costly, disruptive and unlikely to make much of a difference. Instead, we would advocate that the LHINs themselves become integrated back into the Ministry of Health with a robust mandate to engage the public in health system planning.

When the LHINs were first established, we made a point that there was no evidence to suggest the regionalized health systems were any better than a central command-and-control system. Alberta now has both, yet continues to have among the highest health costs in the country, despite having one of the youngest populations.

The reality is that Ontario has both systems. It is clear from LHSIA—the act—that the LHINs take direction from the Ministry of Health and are only accountable to the minister. There appears to be very little independence, nor would we advocate it under the present circumstance, given the absence of any direct accountability to the communities they serve.

That raises the question as to why we have regional LHIN boards when all the real decisions are made by the ministry. It is odd that we have a health system with no central board, but 14 boards at the point of delivery in the regions.

That doesn't mean we believe the public should be shut out of the decision-making process. On the contrary, we believe the integration process should be expanded and enhanced so that the public has an opportunity to not only express their view but also to get full disclosure on proposals that come before the LHINs. We agree with Dr. Hukowich that there is too little information on which to base important decisions.

All integrations, as defined by LHSIA, should be subject to public engagement and full disclosure, including comparable operational costs, costs of transfers, volumes, impact on access and quality to patients, as well as how the change impacts other health providers in the region.

We should also know why the integration is taking place and when it is proposed to happen. We should know what public engagement has taken place to date, including the response to that engagement. We should know how to fit within regional health planning. Integration should also include transfers within the same corporation, especially given amalgamations can bring together very geographically disparate locations. No integration should ever take place where the destination of service is unknown.

We have become very cynical about promises that deleted hospital services will be replicated in the community without any detail as to where or when such services will appear. Our experience is that these services either fail to materialize or are done so in a way where access is significantly reduced.

We also believe that the public should be afforded a longer window to respond to an integration proposal and have the opportunity to depute before decision-makers, whether that is a LHIN board or, in the absence of a board, an appointed panel of experts. At present, only eight of 14 LHINs offer the opportunity to directly depute before their boards.

Ultimately, the LHIN should be responsible for ensuring compliance with the process, but it is the elected officials who must remain accountable for the decisions that are made.

It is our view that the province has repeatedly damaged its own brand by blaming unpopular decisions on the LHINs when the minister continues to retain the right to overturn such decisions. OPSEU president Warren Smokey Thomas will be appearing before the committee next week in Kingston with further recommendations for reforming the LHINs and will elaborate on some of the points I have made today.

Thank you for the opportunity to speak to you today, and I welcome any questions for the remainder of our time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a half. The third party: Ms. Gélinas?

M^{me} France Gélinas: Thank you so much for coming. It's a pleasure to meet you. I'm most interested by the comments that you've made: that "the LHINs themselves become integrated back into the Ministry of Health with a robust mandate to engage the public on health system planning." Take me down the—how would that work?

Mr. Ed Arvelin: We are developing strategies currently within the health care division council, as well as our president Smokey Thomas and Rick Janson, who is our health critic. Our planning is to put back and have the LHIN have maybe more power or more accountability to decision-making so that way it's not an arm's-length process where the minister has the ability to say, "Well, it was the LHIN that made that decision; it wasn't us."

M^{me} France Gélinas: So all of the powers of the Ministry of Health would then be transferred into those new units? Because the LHINs right now have a mandate

for hospital long-term care but they don't have the mandate for primary care, for health units, for many other things, so I'm just curious.

Mr. Ed Arvelin: The strategy will be revealed more. Unfortunately, I don't have the plan right now. Rick Janson and Smokey will be reviewing that in Kingston. I could elaborate further; if you give me your email address, I can have our people forward that strategy to the LHINs presentation as part of the record.

M^{me} France Gélinas: I will be there next week to hear Smokey, so that's fine. Specifically—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. Thank you very much for your presentation. We very much appreciate you being here.

FORT FRANCES TRIBAL AREA HEALTH SERVICES INC.

The Chair (Mr. Ernie Hardeman): Our next presenter is Fort Frances Tribal Area Health Services Inc.: Calvin Morrisseau, executive director. Thank you very much for coming in this morning. As with the previous delegations, you will have 15 minutes time allotted. You can use any or all of that time in your presentation. If you do not use it all and there's some time left, we'll have some questions or comments from the committee. With that, your 15 minutes starts now.

Mr. Calvin Morrisseau: Bonjour. Aanii. It's nice to be here. Good morning, Chair, and all members of the Standing Committee on Social Policy. I have with me my director of behavioural health, Lori Flinders. She also has an Anishinaabe name, but I can't pronounce it. My English name is Calvin Morrisseau and I'm an Ojibway, or Anishinaabe, from Couchiching First Nation. I work as the executive director of the Fort Frances Tribal Area Health Services in the Rainy River area. We offer home care, mental health counselling and outpatient addiction services to those 10 First Nations.

I'd like to acknowledge all of our people who suffer from illness in this great province of ours. I'd also like to acknowledge all our aboriginal peoples across the province who have sadly passed into the spirit world and those who are still suffering from the pangs of illness and disease.

0950

It is well documented that the indigenous population of this great province is the fastest-growing population as well as being the youngest. It is not surprising that the mainstream and indigenous populations have different priorities. It is these differences which I would like to address.

Aside from reviewing all of our differences in terms of world view, I'd like to address some of our similarities as well as some of our solutions to what we in the Rainy Lake area have put forth but which, unfortunately, have been met with silence on behalf of the provincial government and its bureaucratic arm.

I'd like to draw your attention to the three areas in regard to the LHIN; namely, their decision-making process, accountability, and how their obligations were fulfilled under the act. Our intention is not to create discord but, through open dialogue, to create a cohesive health delivery system for Ontario, and the Rainy Lake area in particular, in the most cost-effective manner possible. In doing so, we feel that total honesty must come forth in the most respectful way possible.

Our forefathers teach our people that communication is one of the most important aspects in creating balance in all our relations. It is balance which we seek in terms of services and financial resources. At this point in time, we feel that we have had difficulty in providing services in terms of home care; palliative care; treatment of addictions related to problems and associated illnesses; mental health, including psychiatric services; as well as other community-based programming supported by the LHIN.

In our area, for the most part, we have not had the same level of services in most areas as the rest of Ontario has. We have met with LHIN 14, and our concerns have been well documented at that level. However, nothing appears to be changing. We believe there needs to be an evaluation of the process and how the LHIN provides operational dollars to providers.

For instance, when Fort Frances Tribal Area Health Services goes to any of our 10 communities, it is not unusual for us to see up to 15 clients during one visit. One of our communities is two and a half hours away, and over one hour by dirt road. The community care access centre would see, if they went to that community, only one client, making it a very expensive client service. The new addition known as the rapid response nurse, whose commitment is to see a client within 24 hours of emergency room visits, would take one whole day to see one of our clients in these communities.

My questions at the integrated district meeting were as follows: Why did they not ask us what the best way to service our people was, before implementing something which would not work for us? If they did consult, who did they consult? It certainly was not the community or any of the agencies which provide the service. Why not make that part of an existing service delivery system which already visits those communities?

One of the hallmark features of the LHIN process is integration. We feel that the Drummond report spells out some important points which could spell disaster for the health and social service delivery system in Ontario.

We wish to be greater partners in ensuring two things are accomplished for our communities and Ontario: (1) that services are improved to each of our communities; and (2) that it saves money.

We suggest that there needs to be a greater look at integration at the service delivery level. We feel strongly that instead of using the CCAC model of services for all things, there are some key components which could be integrated within our program, thereby enhancing and reducing cost; for example, access to long-term care and

case-management end-of-life care, chronic disease management, and acute care.

Fort Frances Tribal Area Health Services allows for greater access to home and community support services for our First Nations people we service in those communities. We all know the cost is far less to provide care for people at home, compared to being hospitalized. At Fort Frances Tribal Area Health Services, we have eliminated the middle manager by having our registered staff trained as case managers in our home and community care program.

In the preceding years, we significantly reduced the number of amputations in our catchment area. This allows the health care system to operate more efficiently and give us greater value for our money.

The Drummond report warns us with the following statement: Before health service costs take over all social programs, for a humanitarian Ontario, change needs to happen. We concur, as service providers and leaders in our community, that change must occur.

The Local Health System Integration Act, 2006, was the vehicle which heralded the transformation agenda for all Ontarians. Unfortunately, First Nations people, particularly those in our area, have not benefited from this transformation. We still see high levels of addictions and mental health issues, diabetes and other illnesses which create early deaths for our people. We need the government to listen to us as we strive to prolong our lives with the greatest quality possible, while ensuring our priorities are seen as important and worthy of consideration.

I was raised on my reserve and I was educated in two worlds, first by my father and grandfather, who taught me the way of the land—its herbs, roots and bark. They taught me how to live off the land, and to survive in minus-40-degree weather, skills I have not used often since being taught by my other teachers, the schools.

I am a graduate of Lakehead University, McMaster University and Confederation College, specializing in social work and addictions. I pride myself in being able to walk comfortably in two worlds, that of the Anishinaabe and that of regular mainstream society. In our health and social services world, as Anishinaabe, we must learn healing methods of our people, the Anishinaabe, and those prescribed in the clinical field. We are expected to be skilled in both, because that is the makeup of our people. Some are still very traditional, and some are not. To help our people heal we must be knowledgeable about both worlds.

We do not feel that we can discount the ancient practices of our people. In the area of addiction services, we use the sweat lodge and traditional teachings as key elements to healing. We firmly believe that the restoration of our identity through cultural revival is vital to the welfare of our people.

The LHIN needs to become even more aware of those practices in order to respond in a culturally appropriate way. I applaud their efforts to date; however, to enrich the cultural programming, a wide variety of cultural knowledge must be attained through the utilization of our

medicine people and elders. Immersion must be an increasing part of the LHIN development, especially in our area where such a high percentage of the population are indigenous, each having its own practices and beliefs.

When this is accomplished, you will understand the barriers and challenges faced by our people. For this to occur, consultation is critical. For instance, if we had been consulted, we may have expressed some challenges to the rapid-response nurses in our area. We may have raised concerns that detoxification or in-patient addiction services are non-existent; all people in our Rainy Lake area must travel outside their community to access these services, raising the costs and lowering accessibility to much-needed services.

Lastly, I would like to spell out our position on how the LHIN did in relation to fulfilling the act. We believe that the LHIN has made an effort of inclusion; however, their inexperience and lack of understanding as to the validity of First Nations delivery systems within each community has been overlooked. We believe that, in accordance with self-government principles, a direct-funding relationship which works toward bypassing the current agency, which is mandated to provide services, is critical to our health needs. This direct relationship has already been established, according to my research, in other parts of the province. Not only does it make sense to us; we believe it to be necessary for all concerned.

I would like to say gitchi-miigwichee—a big thank you—for taking the time to listen to us. It is this dialogue which gives us hope that one day we will end the needless suffering of our people and gain affordable and easy access to the services we desperately need.

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The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have exactly four minutes left, so we will just have one caucus do it. It will come from the government caucus: Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation and for your work in your community. I would just like to go back on a couple of questions, but first, in terms of how you were talking about engagement with the LHIN and their engaging you in terms of your participation in helping to serve your population: What would you say works right now and what doesn't, and what would you say would be the most important thing for you in that regard right now?

Mr. Calvin Morrisseau: That's a really big question.

Mr. John Fraser: It is, yes.

Mr. Calvin Morrisseau: It is a really big question. I'll try to answer it.

I think right now, the way the process works—my understanding of the process is that they have the governance govern meetings, and then there are different forums. I think what would be really useful for us is if we could set the agenda, if we could talk about the issues that affect our communities and the challenges we have in delivering the services in the communities.

I mentioned earlier that most service delivery agents will go out and see one client and then back. When we go

out, we see up to 15 clients in one day. In terms of wound care—we've sat with people for palliative care. I think those are the stories that we need to address.

I was just at a governance session of the LHIN. It really had nothing to do with the challenges that we face. It had more to do with the challenges that broader society faces in terms of the hospitals and some of those service providers. We're talking about almost two different worlds. So I'm sitting there and I'm thinking, "I don't even know why I'm here, because it's really got nothing to do with how we do business."

I think that's the message that we have to get to the LHIN. We have to bring that message to them so that they can begin to hear us, because there are ways in which we could help them cut costs. There are ways in which we can deliver more enhanced services that will affect—like I said, we reduced amputation rates by over 90% in our area through good wound care, through diabetes education, through chiropody, which we bring to the communities. So it's not like going to a doctor's where you have to make an appointment. We'll see whoever we can for as much time as we can be there.

Mr. John Fraser: So if you had a recommendation in terms of a vehicle for you to express that, what you're saying is you'd like to set a separate agenda from say, for instance, that. Have a specific committee branch of the LHIN or—

Mr. Calvin Morrisseau: Yes. The other thing is that their board member—I tried to have a meeting with their board member because we wanted to talk about the specific First Nation issues. I was told, "That's not our First Nation representative; that's a LHIN board member." To me, they don't speak for us. Who speaks for us is our grand chief through the treaty agreements with Canada.

Mr. Mike Colle: Just to follow up on that very briefly: Why don't you ask right now what you would like to meet on and when you'd like to meet with the LHIN—right now?

Mr. Calvin Morrisseau: I would like to talk about how we can integrate with the CCAC to provide better services and enhance services in our communities, at a cheaper rate.

We've begun having those discussions, but the meetings have been six months apart.

Mr. Mike Colle: Okay. So you want to make that request of the LHIN—

The Chair (Mr. Ernie Hardeman): Let the man answer.

Mr. Mike Colle: —the CCACs?

Mr. Calvin Morrisseau: Yes, yes.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes your presentation. We thank you very much for coming forward and being so helpful with your information.

BRAIN INJURY SERVICES OF NORTHERN ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is Brain Injury Services of Northern Ontario: Alice Bellavance, executive director. Thank you very much for joining us this afternoon—this morning.

Ms. Alice Bellavance: Yes, it's still morning.

The Chair (Mr. Ernie Hardeman): As with other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you leave time at the end, we will have questions from caucus to use up the 15 minutes.

With that, thank you very much again for being here. The floor is yours for 15 minutes.

Ms. Alice Bellavance: Thank you. Good morning, members of the Standing Committee on Social Policy regarding the review of the Local Health System Integration Act and the regulations made under it, as provided under section 39 of the act. I'd like to thank you for the opportunity to submit this presentation. As indicated, I'm Alice Bellavance, the executive director of Brain Injury Services of Northern Ontario.

I'm actually not going to get into geography and all that other stuff that other speakers have done earlier, because that's usually my favourite rant. I'd rather get into what I wanted to speak about with regard to the LHINs.

We remain supportive of the principles that were laid out by the government when establishing the LHINs through legislation: local planning, accountability, community integration and co-operation.

Making the system work more like a system, leading with quality and safety through continuous improvement: The North West LHIN has developed a 10-year Health Services Blueprint, which is the culmination of extensive collaboration, research and leading methodologies, and community engagement with health service providers and related community partners. Other provincial initiatives, such as the launch of health links, are directed by the Minister of Health and Long-Term Care.

The challenge is of ensuring that "all players play nice in the sandbox together," especially some who are outside the purview of the LHIN or even outside of the Ministry of Health and Long-Term Care. Attempts at standardized software, to be utilized across the province for health links—the care co-ordination tool—hold promise.

There is a need for better communication between the Ministry of Health and Long-Term Care and the LHINs. A number of years ago, the North West LHIN approached the Northwest Regional Mental Health and Addictions Network about our recommendations with regard to the addictions supportive housing initiative, which we happily provided. However, the Minister of Health and Long-Term Care disregarded our recommendations and only funded certain health service providers. A similar process occurred, predating the implementation of LHINs, with regard to health accord funding. If

agencies or networks are consulted for their recommendations, they should be valued.

The LHINs, along with health service providers and the Ministry of Health, need to work collaboratively to review the historical perspective of how some programs and services were funded under specialized initiatives, such as ABI funding—acquired brain injury funding—that was part of the repatriation of Ontario residents from American programs, which began in 1996 and was completed in 2002.

Millions of dollars were flowed through the then home care programs, which predated CCACs, to support community support service agencies—which is what we are—to develop supportive housing, which is now known as assisted living. It also provided intensive in-home support to families to care for high-need individuals at home, to prevent institutionalization of young adults. In the northwest, some of these plans were as much as \$90,000 per annum, which is certainly still cheaper than keeping a person in the hospital.

When individuals died or moved into assisted living, these budgets were rolled into the base of established CCACs. Rather, these funds should be reallocated to dedicated acquired brain injury community support service agencies.

Ensuring value for money; holding the gains; a system-wide culture of accountability: Moving to a three-year cycle of community annual planning submission, or CAPS, which results in the development of our service accountability agreement—in our case, it would be the M-SAA—has been a timesaver and allows health service providers to be more strategic in their planning. BISNO, as a member of a number of provincial associations, such as the Ontario Community Support Association, Addictions and Mental Health Ontario, and Community Health Ontario, has stayed abreast of the negotiations to fine-tune these agreements.

There's also an increased emphasis on performance measure and quality indicators. Though the provincial ones seem to be focused on hospitals, the development of meaningful ones for the community sector will need to emerge.

Improving access; enhancing access to primary care; access to care that people need as close to home as possible: BISNO has been very fortunate, through the provincial ABI strategy and the North West LHIN funding, to implement services to smaller communities in the northwest to support this principle.

Individuals with complex multi-jurisdictional needs unfortunately need to stay in Thunder Bay. The unit cost is high, and we require some economy of scale as well as access to other specialized services which are only available in a larger urban centre. Again, with health links, it is anticipated that this will be further improved.

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Taking a population health perspective and promoting equity, enhancing coordination and transitions of care for targeted populations, and improved health care outcomes resulting in healthier people: The North West LHIN,

through its local administrative process, has given organizations like ours an opportunity to be included at tables to which we were not invited in the past. This is important for sharing visions for health care and best practices. There is a downside for regional providers such as ourselves, as we don't have the resources—human or financial—to be at every possible meeting. Recent moves to use technology will assist with this expectation.

There is an opportunity for the LHIN, Nishnawbe Aski Nation and health service providers in the northern integrated district network, or IDN, to further develop services for First Nations people we serve. As you heard earlier, we have a large aboriginal population in the North West LHIN, and it's about one third of our business in terms of our agency. Many of the First Nations people we serve get stranded in Thunder Bay due to lack of services closer to home, so we've established a business plan: Assisted Living in Sioux Lookout—Acquired Brain Injury, Rehabilitation Services and Assisted Living Project: A Business Case to Drive a Model of Care for the Town of Sioux Lookout and the 31 Remote First Nations Communities It Serves, phase 1. It's a stakeholder consultation and engagement document. It is ready to be circulated; we just need to get some confirmation from a few of the players.

The LHINs are not perfect. However, for BISNO, this has been a huge improvement, and we are prepared to continue to work within the current structure. Political rhetoric about the dissolution of the LHINs would immediately place the health system in crisis and further distract from more immediate issues impacting the delivery of home and community care, since we are the poor cousins to the acute care and long-term-care sectors. For hospitals and long-term-care facilities to remain healthy, we require strong and vibrant community and home care services for our citizens.

Keeping people living with supports in the community and out of hospital is the most effective means of health care delivery. Increasing investments in home and community care will address the alternate-level-of-care crisis and emergency department pressures. Both are provincial targets to be addressed by the Ministry of Health and all LHINs. In the past three years, the LHIN has funded us to support alternate-level-of-care clients in community settings.

We have run out of physical space. We have submitted to the Standing Committee on Finance and Economic Affairs the need for more assisted living, not just operating costs but also infrastructure, and I've attached a copy for your information.

Even with designated increases in the last two Ontario budgets, agencies are still behind on maintaining the necessary infrastructure, as budgets have not kept up with inflation. Many Ontario Community Support Association and AMHO members are now struggling to keep even more clients while solidifying the services they already provide. Acknowledging and addressing this reality is a key determinant in ensuring the effective delivery of quality results that the government and the public rightly

seek. Funding allocations for ALC and/or other expansion is necessary; however, using current funding does erode existing base requirements, thus reducing capacity. Meeting collective agreements, increased utility costs and increased cost of supplies etc. can only result in a reduction of services when base increases are not provided.

The second connected issue is the shortage of home and community health workers. Recruiting and retaining workers is made difficult by the disparity in compensation and working conditions between the community health sector and the institutional health care sector. We must ensure, to meet current and future demand for community and home support services, that there is sufficient funding flexibility afforded the sector to attract and retain qualified workers.

Thank you, and I'll leave the rest of the time open for any questions that you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have just a little over five minutes, so we will start with the third party in the round.

M^{me} France Gélinas: I just want to be absolutely sure that I understood clearly. Since the LHIN has come, your agency, as well as many others like yours in the community sector, feel that they are more valued, that they are being heard more and that they have more of an opportunity to be part of improving the system. Is this the message that you've tried to give us today?

Ms. Alice Bellavance: Absolutely.

M^{me} France Gélinas: Okay. So for you, and agencies like you, it has been positive. How do those positive steps translate into better outcomes for the clients you serve?

Ms. Alice Bellavance: Let me give you one very clear example around the whole alternate-level-of-care situation. People in the back of the room have heard me do this many times. We had a gentleman who had very high needs, very complex needs, who was constantly being hospitalized. I often referred to him as the Six Million Dollar Man because the cost to the system was huge. We finally received funding to get him out of hospital after he had been there for over a year, and we've now had him out of hospital for almost two months. In that period of time, he has not made one 911 call. Previous discharges from hospital, without any planning or consultation with organizations like ourselves or the CCAC to ensure that his discharge to home was going to be good—he would be back in the hospital within three hours after being discharged from hospital.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for coming. We've heard the message around assisted living through—this is day 6 for us. Thank you for going to the Standing Committee on Finance and Economic Affairs. It's really important for community agencies to get out to that group as well.

I'm interested in your comment regarding performance measurement and quality indicators, because it's

very striking that, to date, the indicators are very related to acute care procedures and so on. Have you been consulted by the LHIN on moving forward with some community measures?

Ms. Alice Bellavance: I think that right now, organizations are just looking at measures that are in our own M-SAAs. I know the community support services sector has had some discussion with the LHIN around doing some broader system kinds of indicators. We haven't come up with any yet. I think our focus has been on the blueprint. It has now been focused on the health links and all of the IDN meetings.

Again, as small community support service agencies, where do you divide your time in terms of what your focus is going to be? So there's a bit of a balance struggle there.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much, again, for coming out here today. I just wanted to know if you could elaborate on this. You say that there is a need for better communication between the MOHLTC and the LHINs. What exactly do you mean by that?

Ms. Alice Bellavance: Well, you see, I've been at this for a very, very long time. I've worked in this organization for 23 years, and I was part of a provincial body that worked with the Ministry of Health at that time with the repatriation of people from the United States. We were spending about \$30 million a year in the US to buy services for about 130 people on an annual basis. So the push was to get people home, but that meant we had to look at infrastructure and services in the province of Ontario.

There was a huge committee within the Ministry of Health and Long-Term Care, made up of bureaucrats from the home care sector, OHIP—because, of course, it was OHIP that was paying for people to be down in the United States when insurance funding and/or other funding ran out—people from the institutional sector, as well as the community support services sector, and they came up with plans. They designated Hamilton Health Sciences as sort of the case manager, to case-manage getting people back home from the United States. Hamilton Health Sciences and their acquired brain injury program worked with community organizations to get people back.

But there weren't necessarily mechanisms in place to roll out some of the funding the way that they wanted to roll it out. So they would use home care as it existed at that time and say, "Okay, we'll call it homemaking, and we'll allow this amount of money to pay to support an agency or a family to get a person home." Then CCACs were formed.

So, just for example, just in our LHIN alone, the amount of money—that was supposed to be protected ABI money—is just under \$400,000, that has been rolled over into base somehow. It should be with a dedicated ABI agency.

That history in terms of moving some of those things forward—because the systems have changed about how we're going to manage that—that hasn't kept up with it. We're going to lose some of that historical perspective, and we're not going to remember why or how some of that stuff was funded.

I'm just using ABI as one example. I think there are many other programs within hospitals or community agencies that were funded for certain reasons, because that was the only mechanism available, but it may not still be the most appropriate.

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The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this morning. The time is concluded.

Ms. Alice Bellavance: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you for taking the time out of your busy schedule.

SIoux LOOKOUT MENO YA WIN HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): Next is Sioux Lookout Meno Ya Win Health Centre: David Murray, president and chief executive officer. Good morning, and thank you very much for coming to share some time with us this morning, and some information. You will have 15 minutes to make your presentation. You can use any or all of that in the presentation. If there's any time left at the end, we'll have some questions from our committee.

With that, the clock starts on your 15 minutes.

Mr. David Murray: Good. Thank you very much. I'd like to thank you for the opportunity to present to you today; it's both an honour and a privilege.

I just want to give you a little background. I've been in health care in Ontario for 25 years, and I've lived in over 10 different communities, from the north, in Sioux Lookout, down to places like Hamilton and Kitchener-Waterloo. I've lived in Sault Ste. Marie and North Bay, and I've worked for organizations in the primary care and ambulatory care settings, like the Group Health Centre in Sault Ste. Marie, which has been nationally recognized as a very innovative organization.

I've worked in a small CCAC, I've also run a large CCAC after the amalgamations in southern Ontario, and now I get to be the CEO of Sioux Lookout Meno Ya Win Health Centre, which is a very unique hospital, a beautiful \$140-million hospital that has been built under what was called a four-party agreement. It was the joint effort of the municipality representing the provincial hospital, the federal government, the provincial government and Nishnawbe Aski Nation, acting on behalf of the 28 remote First Nations we serve that are fly-in.

Our hospital serves a third of Ontario's land mass, and we have 20,000 patients arriving each year by air, so it's quite unique. About 84% of the services we provide are to First Nations people from the north.

I should also mention that I was also a CEO of a LHIN, so I'm going to have some good things to say

about the LHIN. I know, reading through, that there have been a fair number of negative things, but let me start by telling you about the North West LHIN. Our LHIN has done a great job, I think, of developing a very sound blueprint for moving forward.

They have developed a very workable plan around some key integration concepts. I think you've heard about some of them. We have the 14 local health hubs that will see integration of services at the local level. This then feeds into the integrated district networks. There are going to be five of them, and each of the five networks has a district health campus to provide specialty services within that area. Then, the overlay on all of this is regional specialized services.

This is a plan that has been well thought out and well documented. It certainly supports local delivery and local decision-making, and it will also improve access to specialized services. We're very early in the implementation of this, but the leadership of the LHIN and the staff at the LHIN have been really excellent. Even if Laura wasn't sitting behind me, I'd be saying the same thing, I just want you to know.

When we look at it, this ability to direct where we're going at the local level is very important. Sometimes we tend to look backwards at the past, as though everything was so much better way back when. I remember a health care system before the LHINs, back in the 1990s, when I was involved in the home care sector and the creation of the CCACs. We had an 800% variation in home care funding by communities. If you were lucky enough to live in the Kingston area, you actually had eight times as much funding per capita as you had in Huntsville to deliver home care. There wasn't an equitable playing field. There were lots of mistakes made when there was central planning.

I know the LHIN legislation is very enabling. What has to happen, though, is that the decision-making has to be passed down to the LHINs—I should say "some decision-making," not all. There are still a lot of things that have to be decided provincially.

I want to focus on some bigger system issues in my short time here. One of them is unintended consequences, decisions that adversely skew delivery patterns. That's one area I want to talk briefly about. Telemedicine and virtual care opportunities are a second, and the last one I'd like to talk about is primary care.

Centralized decision-making often leads to unintended consequences. While the policy decision may look good on paper, oftentimes we get unintended consequences. I'll give you a couple of examples. Wait times: The Wait Time Strategy has been really good at reducing the waits for hip and knee surgeries, and there's been a lot of pressure and focus to drive hip and knee surgeries through rewarding hospitals to do this and setting targets for wait times and the number of surgeries done. When I was with the LHIN in the northeast, this had a particular problem especially in Sudbury, which didn't have the orthopedic capacity to do all of the wait time, and we ended up unwittingly moving resources away from doing

oncology surgery and covering the ER with orthopedic surgery to doing wait time stuff. So it was an unintended consequence of the Wait Time Strategy.

Another one is ambulance services. We devolved ambulance services, took them away from hospitals, and set them up under either municipalities or district boards. In the north this has been pretty much a disaster in small communities. We now have stand-alone ambulance services with highly trained, well-paid staff, who sit in garages waiting for infrequent calls. These people used to work in the hospital, were far more valuable, and we could be using them more extensively in the hospitals today, but we have a model that, once again, works in large parts of Ontario, but certainly in rural and northern communities it doesn't work that well.

One of the other things is that sometimes decisions are made for very good reasons. Underservicing: During the 1990s we had a lot of problems trying to access specialty services. In our three districts here—Kenora, Rainy River and Thunder Bay—we had a need for 10 psychiatrists, and there was only one here in the 1990s. So the solution, on an interim basis, was to have psychiatric outreach from southern Ontario. We're 20 years later and that interim solution has become pretty permanent. Just last week, I got a beautiful annual report from the Ontario Psychiatric Outreach Program, from Toronto, and now what we've done is we've taken what was an interim solution and it's become a permanent solution, and it has skewed the way we deliver health care in our region. There are several examples of that.

One that I'd really like to talk about is the northern travel grant. This year, it's expected to cost close to \$70 million. It's about \$300 per person. There'll be over 200,000 people accessing the northern travel grant. That's roughly 1,000 people every working day, Monday to Friday, on the road going to access services from a specialist. That was started at a time when we didn't have enough specialists, so people had to travel to get services, and the northern travel grant was the way of lessening the load, financially, on the patient who had to access services. The problem is that we're now spending as much getting people to the service as it is to provide the service. The \$70 million actually supports about \$30 million of consultations, so we're really spending a lot of money moving people around. Those dollars could be better used to provide services in the communities where the people are coming from.

There's also a different cost, other than the poorer access and the inconvenience etc. In Fort Frances and Atikokan, just before Christmas, we had two different car accidents that killed three people: a husband and wife, and a fellow in the other one. In all three instances, they were travelling for appointments, so there's a tremendous personal cost in some of this as well. I did mention the fact that we're addicted to the northern travel grants and moving people around to support specialty services in urban centres.

One of the things we could be doing is a much better job of telemedicine and virtual care. Just as a disclaimer

here, I'm on the board of OTN, so I'm going to speak, obviously, positively about the work that OTN has done. OTN is the world leader in telemedicine, but one of the biggest challenges they continue to have is, is it an option? They will do about 400,000 consults—and remember I said that there are 200,000 northern travel grant consults—there are 400,000 virtually done by OTN, which is a good number. OTN's budget is only \$22 million, so you're getting good value from OTN for those 400,000 consults, but remember, there are about 170 million consults in Ontario each year. So even at 400,000, we're not even scratching the surface with OTN, and this is something which is going to need a lot more muscle put behind it by decision-makers to make sure we drive a system where we use virtual care.

Just as a comparator, Alaska—a very similar geography, obviously, to remote parts of Ontario—for each dollar they spend on telemedicine, they save \$11 in travel costs. But more importantly, for specialty consults, if you are in a remote community in Alaska and you need to see a specialist or have a consult with a specialist, 40% of the time you'll have that consult within 60 minutes; 60% of the time, within four hours; and 70% of the time, within 24 hours. In Ontario, we measure this in weeks and months, not in days and hours. So that's something to consider.

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The last area I just want to touch on—and this is a soapbox for me—is primary care. Having worked a lot in primary care—this is the engine that drives the health care system. I really think we have to find ways to bring primary care under the LHINs. The LHIN is the transmission that will connect it to the rest of the system. Right now, it's like an engine that's just running in neutral; we're not going anywhere. The ministry has tried dozens of different APPs and different arrangements. I'm here to pitch an idea that I think should be considered.

We have a model in Ontario that is very successful—Cancer Care Ontario—that has strong provincial guidelines and goals and objectives, and a very strong local delivery system. CCO has worked on and has done a tremendous job of improving cancer care services in this province. Maybe we should think about PCO, “primary care Ontario,” and put together all the APPs, the CHCs and the CCACs as well—one of the misunderstood organizations in Ontario—as well as OTN and eHealth into a primary care juggernaut that could really change the way in which we deliver primary care and make it far more useful and accessible to the people of Ontario.

That's my pitch for the things that I think the LHIN should be doing. Our local LHIN is doing a good job. Thank you for the opportunity to present today.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about a minute and a half for each party, so we will start with the government side. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Mr. Murray, for some really innovative ideas. I think a few of us jumped when you talked about “primary care Ontario,” sort of modelled on CCO, because several of us have also

advocated for a “mental health Ontario” as a potential way of bringing services together with strong provincial guidelines.

Could you perhaps expand a little bit on that idea—what you see as the benefits and how would you see them interacting with LHINs?

Mr. David Murray: Much the same way as CCO. What you need is a provincial organization which can set down the big ground rules of how it's going to work. Obviously, there's going to be resistance from the OMA and others. There's a lot of inertia in the existing system. We have so many different players in primary care now; I call it the alphabet soup of alternative payment programs. It's time to bring them together so that they have common goals and objectives.

Oftentimes, there are a lot of unintended consequences, as I was mentioning before, with APPs. You introduce APPs, and suddenly physicians walk away from their hospital work and they're no longer integrated with hospitals, or they stop providing other types of services that they used to do: supporting long-term-care facilities etc.

There's a fair number of things where we've got to standardize what happens in primary care, but you have to leave enough flexibility to make it work at the local level. In my particular hospital—I'm in a town of 5,000 people—we have 78 physicians on our staff. They're not all there all the time, obviously, but we do have around 18 regular physicians and we have almost 40 locum physicians who are fairly regular ones, and then others who just come on occasion.

The Chair (Mr. Ernie Hardeman): We'll have to stop there for the question from Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Murray. We're really intrigued by the concept of PCO. Like Ms. Jaczek, I'd like to learn more about it. Do you have any written material or anything else that expands a little bit more on the concept?

Mr. David Murray: As a matter of fact, I do. I think I might have even emailed it to you once upon a time.

Mrs. Christine Elliott: All right, I'll have to go back. As part of the submissions to this or—

Mr. David Murray: No, no. This was a couple of years ago, probably. I sent it to a whole bunch of—all three parties and people who were the health critics etc., and the minister.

Just to expand on it, the reason that I would make sure that eHealth and OTN were rolled into that: Virtual care probably provides us with the greatest opportunity to have a sustainable health care system. If we don't get it right at our level, we're going to soon see it happening around us. People aren't going to wait for the health system to respond. They'll just pick up their iPads and start doing it themselves.

Mrs. Christine Elliott: Would you mind—

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Gélinas.

M^{me} France Gélinas: So I take it that we will all receive a new, shiny copy of your ideas as to how we move towards “primary care Ontario”?

The idea of bringing primary care under the LHINs has been presented many times. You are presenting it in a way that could actually make it feasible, because, as you say, the pushback from some of the players is already there and will be tremendous. If we could move forward towards something better, then there’s certainly value in sharing that with us.

Continuing on that thought, you would see not only primary care but you would see OTN and e-Health—all of this—also falling under the LHINs, so there would be 14 OTNs? How would that work?

Mr. David Murray: No, they would be there. Part of the reason to bring OTN is to make sure that the virtual care opportunities in Ontario are right across the province. There’s been a lot of discussion, as you know, about CCACs and their role. CCACs are very powerful organizations and they use a common system right across all 14 CCACs. They have 236 offices across the province. They touch every part of Ontario, so it’s a ubiquitous system. I think that OTN could bring that to the table, as well.

M^{me} France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate it. The time has been consumed.

Mr. David Murray: Thank you.

ST. JOSEPH’S CARE GROUP

The Chair (Mr. Ernie Hardeman): I understand the next presentation is not yet here: St. Joseph’s Care Group.

Ms. Tracy Buckler: We are here.

The Chair (Mr. Ernie Hardeman): Oh, we are here. It’s just that our good and faithful doorman didn’t want you to come in.

Interjection.

The Chair (Mr. Ernie Hardeman): It must have been time to take a break.

Thank you very much for coming in. We have Tracy Buckler, president and CEO, and Ray Halverson, past chair of St. Joseph’s Health Group. Thank you very much for being here this morning. You’ll have 15 minutes in which to make your presentation. You can use all or any of that time for the presentation. If there’s any time left, we’ll have some questions from the members of the committee.

With that, the floor is yours.

Mr. Ray Halverson: Thank you, Mr. Chairman and committee members. My name is Ray Halverson. I have served, as a volunteer community member, as a director on the board of St. Joseph’s Care Group in Thunder Bay for the past six years. With me is Tracy Buckler, the president and CEO with the care group.

Thank you for giving us this opportunity and thank you for travelling this long distance to Thunder Bay and for bringing this warm weather with you.

St. Joseph’s Care Group, established by the Sisters of St. Joseph in 1884, is a regional health care provider with program areas including seniors’ health, rehabilitative care and chronic disease management, and addictions and mental health. We have eight sites located throughout Thunder Bay and we employ over 1,700 people.

I would like to make a few personal comments from a board member’s perspective before turning it over to Tracy. I am here today to express my support for the Local Health System Integration Act and the LHIN. I believe the act is sound. It offers an excellent opportunity to improve our health care system and, at the same time, make it more affordable. I believe also that the local/regional concept, as envisioned by the LHIN structure, is a good one, and that governance by local volunteer boards is of much benefit to our region.

The North West LHIN has done an outstanding job in providing education and capacity-building for both the local board directors and the health care administrators. It has provided extensive local engagement and consultation, the nature of which we have not experienced before.

Challenges that we experience in the northwest are going to be unique to our area and can be dealt with best by local discussion and problem-solving. As we respond to the needs of our population, we are beginning to see successes in program changes, partnerships and mergers that will result in better client care.

In my opinion, we now need to move to a strong focus on implementation of the intent of the act. Health service boards and the leadership of all our organizations will need to take a stronger system perspective and address in particular any duplication and fragmentation that exists. I believe this could best be addressed by a regional representative implementation team that would extend beyond the voluntary integration approach currently being used.

St. Joseph’s Care Group supports the local health integration network structure overall and we appreciate the opportunity to provide constructive feedback to improve the effectiveness of our current health care system.

I will now turn it over to Tracy to provide more on the management perspective. Tracy?

1040

Ms. Tracy Buckler: Thanks very much, and good morning, Mr. Chair, and committee members. Thank you for the opportunity to speak with you this morning.

Mr. Murray went before me and stole some of my material, so I’m not going to repeat some of what you’ve heard already. Just to give you a little bit of context, I’m in my 29th year in health care in the province of Ontario and so have seen a fair amount of changes in structure and systems over time.

Also, to give you a little perspective on St. Joseph’s Care Group, as far as our mission to meet the unmet needs of people in northwestern Ontario, we believe that our mission aligns very well with the intent of the LHIN

system from a local and regional focus and perspective. Our strategic plan fits very well with the LHIN priorities—the integrated health system plan.

We do have a regional obligation. You've heard about the challenges of land mass: 47% of the province's land mass and 2% of the population. So certainly trying to reach out in a way that's effective and provides care in the best manner for the people we're here to serve is an ongoing challenge and something that we strive towards every day. The low population, of course, has its own issues and challenges with respect to some new funding formulas and some population-driven challenges that way.

We want to comment on the North West LHIN particularly, as far as the benefit to the people of northwestern Ontario and to the health service providers. There are a few reasons for that. One is that the responsiveness to local and regional issues—geographical and the small and rural challenges—is better understood when you have some local context.

We have the opportunity to develop professional relationships perhaps on a closer-to-home basis than we might otherwise in previous systems. Also, leveraging the existing expertise of voluntary governance structures has been of benefit.

We understand that the Ontario Hospital Association and various other bodies that represent parts of our business have provided some written submissions, so we're not going to repeat that today. But I would like to just provide you with a bit of local perspective through the four themed areas that have been identified in the review, and I should say that these comments and suggestions are really intended as tweaks or opportunities to consider within the LHIN structure and the LHSIA review.

The first theme, then, making the system work more like a system: Ray has mentioned the education that has been provided, so the governance-to-governance sessions have been a real benefit to the various independent boards to understand the concept of integration and what that might look like and also to provide a level of understanding of the LHIN's role and function. We also think that it's important that there's continued work on developing that shared understanding of integration. I think people become a bit fearful and threatened by the big "I"—the capital "I" word. Integration can be a continuum, whether it's a partnership, a memorandum of understanding or a true merger in the sense of an amalgamation, so I think there's a continuum that needs to be recognized there.

The other couple of points, as far as making the system work more like a system: The opportunity is really that system outcomes can be measured more consistently. We need to focus on the accountabilities and the efficiencies in the system to enhance the effectiveness of all health service providers in our region.

We talked about the independent voluntary governance. We would suggest that similar elections or appointments processes for the LHIN board might be something

beneficial in terms of good governance practices; that might be something to consider.

The other areas, the opportunities, the LHIN structure, the responsibilities—we would appreciate further clarity and definition of roles. I think that ongoing communication around the connectedness between performance and planning responsibilities is important.

You've also heard about some provincial or centralized initiatives versus the local autonomy. We think there's a role for both as far as the provincial standards and some standardization across the province but also to allow the local LHINs more autonomy to be able to do what makes sense in their region, and you've heard about some of the unique challenges of the northwest.

Secondly, the theme around ensuring value for money, and that's always a significant and important one: We believe there's an opportunity for some further clarification on the role of the ministry versus the LHIN, particularly from an operational perspective, as well as with respect to capital development, because there's still some centralized ministry role, for sure—just to clarify those responsibilities as to where we need to go for what, from a health service provider perspective, and how we might work together to streamline some of those processes would be extremely helpful.

We also wondered about the potential to integrate further roles into the LHIN structure from a capital perspective, from a quality perspective, and what possibilities there might be. Primary care has been talked about a couple of times. We wondered if there was opportunity to consider inclusion of primary care into the LHIN structure. It's certainly a significant part of an overall health care system and a significant amount of money being spent in primary care. It seems to me that if we worked in a truly integrated fashion and had opportunities for further dialogue and conversation with the primary care sector, things would be a lot better for the people whom we're here to serve.

We also believe that there's a role for the LHIN to assume some centralized command and control, if you will, in times of crisis; yet on the other hand, there's the LHIN's role for planning, responsibility and not managing daily operations. Those things need to be clarified.

I can give you an example of a program that, in Thunder Bay, with support from the LHIN, ensured value for money and improved access for people. We run a program for withdrawal management. The withdrawal management program was very over-subscribed. You've heard about some of the population challenges in the northwest. We were able to expand that program to allow for additional care within one of our centres and significantly reduce the visits to emergency departments, significantly reduce the visits to the jail, the police responsiveness. That was a great example and continued success as far as the value for money. As well, Laura mentioned the GAPPS program. We're one of the three organizations that provides that service to allow access for people who might not otherwise receive care. Particu-

larly in addictions and mental health, there's a big challenge.

Improving access to care is pretty significant and very important with this geography. You've heard about OTN; you've heard about telemedicine. The health links opportunity: It's a little early to tell what the successes might be as far as health links, but we believe that that may really improve access to care for those who need it the most and that telemedicine or OTN would certainly help that as well, given the dispersed population and our geography. The Health Services Blueprint that the LHIN developed, as far as the regional role, the local health hubs and the integrated district networks, seemed to fit well with the health links model. Again, we'll work in partnership to make that happen and hopefully reduce some of the fragmentation and try to look at better opportunities to improve access for the people who need our services.

Finally, the fourth theme, the population health perspective and promoting equity: We wanted to highlight that community engagement is a responsibility of not only the LHINs but every health service provider. We think that's a shared responsibility that we take quite seriously. Also, the quality of service that's provided: As local independent boards, our board has a responsibility to ensure the quality of care and service that's being provided.

We expect and acknowledge the expertise within the health care system—that not one person knows everything and that across the system there's a lot of expertise that can be leveraged to make sure that the services are the best possible. We also believe that the LHIN needs to advocate for our regional needs, as our region's planning body, and needs to know the gaps and the needs of the people who we serve.

Just in closing, we believe the intent of LHSIA and the vision for the LHIN structure has been more beneficial than the previous centralized model. There are still significant opportunities for improved care; there's much more work to be done. Potential cost savings will be realized by clarifying some of the sections of the act and with a concerted implementation that will ultimately better serve the people of the province by having a local and regional systems approach.

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The LHIN needs to work in close collaboration with all of the health service providers to ensure continued quality and safe care for the people that we're here to serve. I guess we all need to be system thinkers and certainly try to remove those silos to make sure that we're doing the best job possible.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just over a minute left. The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for coming today and bringing us perspectives from the St. Joseph's Care Group. You mentioned that there are many things that still need to be done; we appreciate the things that are working. Can you tell us what your first priority

would be for improved care with respect to the operation of the LHINs?

Ms. Tracy Buckler: I think that ongoing work needs to be done. As far as the first priority, we need to talk about more serious implementation of opportunities for integration in that continuum that I mentioned. Whether it's through partnerships or further memorandums of understanding, we need to get to the heart of the matter, which is to get a few things accomplished. There's been a lot of education, a lot of planning and a lot of development—which needs to happen, absolutely. Now we believe that it's time to get to implementation.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate your time, and sorry I didn't recognize you when you were here.

WESWAY

The Chair (Mr. Ernie Hardeman): The next presentation is Wesway: Margaret Boone, president, and Daniel McGoey, executive director. Thank you very much for taking the time to come and talk to us this morning. You will have 15 minutes to make your presentation. You can use all or any of that time as you see fit. If there's time left at the end, we'll have questions from the committee. With that, thank you very much again for being here, and the clock has started ticking.

Ms. Margaret Boone: Thank you very much for the opportunity to be here. I think it's really important that we continue to look at, evaluate and examine the things that are going on in health care within our province. I'm going to just spend a little bit of time describing Wesway, and then I'll turn it over to Daniel.

Wesway is a non-profit organization, and it's been going now for about 40 years. It's a community-based respite service for families, and those are families of individuals who are dependent on a family caregiver. The range of the individuals that we service is from right across the lifespan, from birth to old age, and many of them may be either frail seniors or people with physical activities, or maybe people with Alzheimer's or other kinds of dementia, or anyone, really, who is needing some family care.

We serve the city of Thunder Bay, plus into the rural area. There are 40 communities that we service as well, so that's a pretty wide range of services across north-western Ontario. I think you can probably imagine the size and the range of the communities across north-western Ontario. It means that Wesway has to be pretty flexible and pretty innovative in order to meet those individual needs and to meet the larger goal of looking at areas of cost reduction. I think that's one of the areas that LHINs have been able to help with, in terms of looking at some innovative ways and being able to test out some pilot projects in those communities.

Respite care is what we offer. That's our focus; it's all respite care. I'm sure that most people recognize that, if

you are responsible for constant caregiving of a family member, it's extremely stressful. It's time-consuming, but it's very stressful. It often can result in some real social isolation and some depression. People tend not to look after their own health, simply because they can't sometimes get to the places to look after their health. So it really starts to take a toll on the caregivers. When it takes a toll on caregivers, they can then become people who are needing the health care system as much as the individual.

What Wesway is able to do is give some respite to those people, even to attend to their own health needs or just to get a break, to get rest and be able to build themselves up again. So it's a very critical service within our health care system. We provide support for the families, and also, as I say, it allows people—not only care for the caregivers, but it allows the individuals to be able to stay at home, to have some dignity and to not be using up, essentially, very expensive and otherwise costly kinds of health services.

We're very much part of the continuity of care. To be able to provide a nice, smooth continuity of care for individuals, it really depends on integration, co-operation—people working together. To be able to go from a community into an acute care setting and back again and so on really means that we need people who are working together.

I think Wesway has had a long history of doing that, being able to co-operate and look and search for areas of integration, but this has certainly been enhanced with the work going on most recently by the LHINs. Particularly, as a board member, I've really appreciated their governance-to-governance meetings, which brings boards together to look at—if we're looking at policies and setting policies for our agencies, we're able, at a board level, to look at some of those as well.

We think that through that kind of—not only does it provide for a smooth transition and continuity of care, but it also, as I mentioned before, provides for areas of cost-cutting, because we don't have a lot of duplication. We're using and we're maximizing the resources that we have when we're able to work together.

The LHIN has certainly provided us the opportunity as a community group to come to the table, to work with others, to be heard, so that people know what we're able to offer, and as I say, then start working together to provide that kind of integration. They've also assisted with things such as pilot projects. As I mentioned before, we're servicing 40 communities in the region, so we need to look at some innovative ways, and they've been able to assist with pilot projects to look at some of those as well.

I think they recognize the need to decrease the stress and the increased use of emergency, very often by people who could be better cared for at home or have some of their immediate needs attended to in more of a home setting. That's one of the ways that Wesway can work with them.

I'm just going to close off and hand it over to Daniel, but before I do that, I just wanted to quote the importance of what we do from one of our family caregivers. I'd just like to read this quote to you: "I was caring for my husband 24 hours a day, and I wasn't getting any sleep. I was absolutely exhausted. I was at the end of my rope. But with Wesway's help, I was able to get someone to stay with him at night. It was such a blessing. I was able to look after him during the day because I was getting adequate sleep at night. I'm so glad I was able to keep him at home during his final days. It's where he wanted to be." I think that kind of sums up, in a way, what Wesway is able to do within the health care system.

I'll hand it over to Daniel.

Mr. Daniel McGoey: When I listened to your comments and your questions this morning, it's obvious that you've been at this a long time. You say "six days of intensive listening." You've heard a range of things. I think you asked a question that made me sit in my chair and say, "Oh, my God, she just took away my entire thing that I had to say." So I'd actually like to go back to your question. I think it was very, very informed.

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The messages we have are relatively straightforward: that we believe a continuum of care is the answer. We believe that primary care has its role, acute care has its role, long-term care has its role, but community care has an enormous role, because we know as individuals and we know as people who have constituents that we want to age in our place, in our homes, in our community, and we want care as close as we can.

We also know that there are four types of people in the room. There are people who have been the recipients of care, people who will be the recipients of care, people who have provided care or will provide it, and we know that the care of caregivers in homes of loved ones is the backbone of the Canadian health care system. If informal caregivers stopped providing care, the system would crash, so those are the people we have to support.

The community support sector, of which we're a part—you've heard this earlier, and it dealt with your question: The LHIN has allowed us to get at the table and to have a voice and to bring our focus to the discussion, which is that we need local planning, we need local solutions, we need support to caregivers. The health care field is a very large field, full of many, many groups, some very, very large and some very, very powerful. In the community support sector, it has in the past been very difficult to get to the table, to get through the rhetoric and to be heard. If nothing else, from our experience, that's what the LHIN has done. It has been that third party who has brought everyone to the table and said, "Let's respect everybody's roles, let's respect what everybody does, but let's make sure that everybody is doing what they do best and not everything else as well."

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about five and a half minutes. We will start with the PCs. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. I think this is the second presentation you've given in a few weeks. I think you presented as well to the developmental services group?

Mr. Daniel McGoey: No, we provided it to the financial standing committee.

Mrs. Christine Elliott: Oh, financial. Okay, that's where I saw it, then.

Mr. Daniel McGoey: Yes.

Mrs. Christine Elliott: Thank you very much for being here anyway today, and you are performing a vital service in the community. The caregivers do need to be supported. We've certainly heard that from many groups.

What else could the LHIN do to further support the work that you're doing?

Mr. Daniel McGoey: I think they are doing it. I think that health links, if it rolls out properly, will be an enormous benefit because the principle of health links is twofold. Right now, they're focusing on the 1% and the 5%, which is a lot of the issue of primary care and acute care, but once that's rolled out, what they are looking at is community support services to make sure those people are diverted from the acute care hospitals. So I'm very excited at that because I think we will be able to perform a role that will allow acute care to do what they do best.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Gélinas?

M^{me} France Gélinas: You are the CEO and you are the president of the board. You can see that having a board adds value to your organization, and I'm sure you volunteer your time because you see the value of it. I would like to have a little bit of your insight as to what you think of the board of the LHINs, the process of having them nominated by order in council with the ministry, rather than the way that you choose your board members. Does that work for you? Is there something we could do better, given what you know from your own agency?

Mr. Daniel McGoey: Again, assuming that order in council is based on competency, we have no issues.

M^{me} France Gélinas: That's a big assumption. It's not always the case, is it?

Mr. Daniel McGoey: It would be one thing we would hope for.

M^{me} France Gélinas: Okay. Anything else?

Ms. Margaret Boone: I like the system because I think it takes it a little bit away from getting people on the board who are just the people you know. I think it gives it a much broader base. People look further within the community and the region when they're developing that board. So I like the system.

M^{me} France Gélinas: You yourself were elected at the AGM by the people who are members of your corporation?

Ms. Margaret Boone: Yes.

M^{me} France Gélinas: Okay. You realize that, at the LHINs, that's not how it's done?

Ms. Margaret Boone: Oh, I know that.

M^{me} France Gélinas: Okay. What are the advantages of the way that you got on the board versus the way people get on the boards of the LHINs?

Ms. Margaret Boone: The advantages for our board? Well, I think that for some of us, if we have an interest in an area, we'll approach that group to go on the board. Other times we're asked because people know we have certain abilities and qualifications. They will ask us to go on the board—

The Chair (Mr. Ernie Hardeman): We'll have to stop it there. To the government side.

Ms. Helena Jaczek: Thank you so much for coming in. Obviously, you're fulfilling a very important need in the community, so thank you for the work you do.

I presume that your employees are mostly PSWs. Would that be correct?

Mr. Daniel McGoey: No. Actually, what we've found is that we don't go for the regulated professions. Because the needs of families are so distinct, and we do serve families from birth to old age, we often find that, depending on the needs of the family, different workers are required. For children, one of the most effective workers we have is outdoor recreation.

Ms. Helena Jaczek: I see. So it's very individualized. Do you do some sort of training in-house in terms of standardization?

Mr. Daniel McGoey: Absolutely. We make sure that we've done quality assistance, we've done sensitivity, we've done back care, we've done medication policy, we've done health and safety, HR—absolutely.

Ms. Helena Jaczek: Are you finding it difficult to recruit people to provide this care?

Mr. Daniel McGoey: Yes, but for perhaps slightly different reasons. Our workers work anywhere from an hour and a half a day to six to seven to nine hours a week. What we find in community supports is that our workers are employed in at least four other agencies.

Ms. Helena Jaczek: I see. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much for your presentation. It's much appreciated.

ONTARIO NATIVE WOMEN'S ASSOCIATION

The Chair (Mr. Ernie Hardeman): Next is the Ontario Native Women's Association: Kezia Picard, director of policy and research.

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, it'll start by itself.

Dr. Kezia Picard: Oh, okay.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use all or any of that time. If there's any time left over at the end of your presentation, we will have some questions and comments from the committee. If there's no time left over, that's totally up to you. Right

now it's your 15 minutes, so thank you very much for being here.

Dr. Kezia Picard: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Dr. Kezia Picard, and I'm the director of policy and research at the Ontario Native Women's Association.

As Ontario's voice for aboriginal women and their families, the Ontario Native Women's Association is pleased to present to the Standing Committee on Social Policy as it begins its review of the Local Health System Integration Act. As director of policy and research, I'll probably be talking more about high-level policy issues here.

The Ontario Native Women's Association, ONWA, is a not-for-profit organization that was established in 1972 to empower and support aboriginal women and their families throughout the province of Ontario. ONWA's guiding principle is that all aboriginal ancestry will be treated with dignity, respect and equality, and benefits and services will be extended to all, no matter where one lives and regardless of tribal heritage.

This presentation is informed by our knowledge of the local health integration networks, or LHINs, the act, as well as our experience working with aboriginal women and their families. ONWA's submission is also shaped by our overarching mandate to provide the supports and resources necessary to empower aboriginal women and their families, build capacity within our communities and increase opportunities for collaboration for aboriginal women at the provincial, local and federal levels.

ONWA strives to address and respond to the service gaps and barriers that continue to impact our people, recognizing that aboriginal women continue to be marginalized by our system.

ONWA is the voice of aboriginal women in Ontario, and as such must ensure that the needs of aboriginal women and their families are reflected in all government policies and legislation. This is particularly needed at this level, in terms of the act being addressed today, because aboriginal women experience health disparities. For example, aboriginal women, as a population, have been identified as having the poorest health and shortest life expectancies in Canada. Aboriginal women and girls are three times more likely than non-aboriginal women to be victims of violent crime, and nearly seven times more likely to be victims of homicide.

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Aboriginal people in general are likely to get type 2 diabetes, the most common type of diabetes. Up to 40% of adults on First Nations reserves have type 2 diabetes versus 7% of adults in the general population.

Aboriginal women are three times more likely than non-aboriginal women to contract AIDS, and we know that the highest number of HIV/AIDS cases that are being diagnosed are in aboriginal women. Urban-dwelling aboriginal women have lower life expectancy rates, a higher incidence of victimization and violence, lower rates of employment and income security, in-

creased likelihood of living in inadequate housing, and poor access to health services.

From ONWA's perspective, there is ample space for improvement in how LHINs engage with aboriginal women. There needs to be more emphasis upon health equity, the social determinants that contribute to poor health, culture-based services and the creation of aboriginal support systems within communities across the province—for example, facilitating sharing circles or peer support groups in a culturally safe way.

To achieve these changes, ONWA urges the committee to consider the following directions for change:

(1) Mandate the LHINs to incorporate a health equity approach, with considerations to the impact of social determinants of health on aboriginal women, and recognize the impact of intergenerational trauma on the health of aboriginal people.

(2) Enhance the capacity of the LHINs to support indigenous organizations to deliver culture-based, aboriginal-specific care that is responsive to the needs of our local communities.

(3) Widen the LHINs' scope to ensure that health equity outcomes, supportive services for mental health and addictions patients, and culture-based services for aboriginal people are included as part of the LHINs' strategic and operational plans.

(4) Support strong, aboriginal-specific, culture-based services that are informed by community engagement and input. The Aboriginal Health Policy for Ontario set precedent by recommending community control over program delivery and the authority to redefine programs as needed. ONWA envisions the LHINs supporting such community-based initiatives.

ONWA views health from a holistic, aboriginal perspective, recognizing that in order to feel healthy, we must not only be physically healthy but also mentally, spiritually and emotionally balanced. ONWA feels strongly that the LHIN must broaden and expand upon its approaches to health care so that it supports a holistic aboriginal health practice.

In reviewing the act, we are cognizant that the stated purpose of the LHINs is to improve the health and well-being of Ontarians. Beyond the preamble, however, the act shifts from focusing on improvements in health care to service integration. Though integration is fundamental to the operation of the LHINs, ONWA feels strongly that the goal of improving holistic health, supporting indigenous organizations to deliver culture-based services, and addressing the social barriers to health should be a primary goal of the act.

The LHINs' long-term goal should be fostering collaborative partnerships between themselves and aboriginal leadership. Under subsection 14(3) of the act, the ministry is mandated to establish an aboriginal health council to ensure that the needs and priorities of aboriginal peoples, including women, are heard and addressed. A comprehensive evaluation of the LHIN's roles and purpose in regard to its ability to adequately serve the needs of aboriginal people must be conducted.

In order to reform the LHIN to a system that will fully address the unmet needs of aboriginal women, ONWA has identified a number of outcomes:

- (1) improving health equity outcomes for aboriginal women and their families;
- (2) increased aboriginal involvement in the LHIN's planning processes;
- (3) increased capacity of indigenous organizations and aboriginal communities to provide input throughout strategic planning and evaluation;
- (4) increased emphasis upon preventive population health; and
- (5) establish the aboriginal health council.

In order to implement these overall objectives, the committee must comprehensively examine the current act and engage in consultation sessions such as this, seeking out input from aboriginal communities and organizations on how best to amend the act so that it is cognizant of and informed by the health care needs of our communities and people.

I'll go over some of those recommendations in a bit more detail.

The health equity outcomes: On the issue of health equity outcomes, ONWA has duly noted that these are only referenced in the preamble. ONWA feels strongly that health equity outcomes and the social determinants that are linked to them are often at the root of the ill health and lack of balance experienced by aboriginal women. Poverty, intergenerational trauma and the lack of affordable housing all impact aboriginal women's health, demonstrating that health care is more than treating just physical illness.

All research indicates that aboriginal women have worse health outcomes than the general population. Aboriginal women have a lower life expectancy and higher infant mortality rates. We know that circulatory diseases and injury account for nearly half of all the deaths among First Nations people. We know that the province and the LHINs can do substantially more to advance equitable health outcomes and reduce these health disparities.

The ministry-designed health equity impact tool, which has been designed for the specific purpose of identifying and mitigating unintended health impacts by health initiatives, could be instrumental in ensuring that the programming offered by LHINs or any other provincial initiatives responds appropriately to the health issues faced by aboriginal women.

On our second point, increased aboriginal involvement in the health planning process: Indigenous organizations and communities must be involved in health planning that is responsive to our input and concerns. We ask that LHINs be respectful of the rights of aboriginal people to be involved in making decisions regarding our health.

As aboriginal women, we have historically been subjected to government decisions which were not in our best interests. This can no longer continue. LHINs must acknowledge and honour the constitutionally protected right of aboriginal peoples to actively participate in

health planning systems and policies that will impact our health and the health of our future generations.

Additionally, as aboriginal people have cultural beliefs that guide our perspectives around health, we would like to see opportunities where our traditional medicines and healing practices could be integrated into the western model of health care. We envision a health care delivery system that is developed and operated by aboriginal people, informed by our cultural beliefs and traditions, integrating our traditional medicinal healing practices, and supporting our unique needs as a population. This is our end goal.

Speaking about point number 3, on community engagement: Failure to include aboriginal people in the development, implementation and evaluation of health programs and services is the primary reason why these services fail to improve the health of aboriginal people. LHIN board members are, in the main, unaware of the lived experiences of aboriginal people. It is for this reason that we recommend that LHIN board members attend engagement sessions. It is a significant amount of effort for many aboriginal women to come to these engagement sessions, depending on transportation, health care, child care needs etc. The LHINs should, at a minimum, actively listen at these sessions to hear their personal accounts and recommendations of people using their services. This will give them the opportunity to learn about our lived realities as aboriginal women.

Mandating that the LHINs "shall engage the community of diverse persons" does little to reassure aboriginal women that our voices will be heard and that our issues will be addressed in LHIN policies. ONWA also objects to the classification of aboriginal people as a diversity group. As aboriginal peoples, we have constitutionally protected rights which must be recognized by the LHINs and the act.

On point number 4, on a preventive population health approach: ONWA stresses that, while the effective treatment of illness is a necessary and critical component of the LHINs' health strategy, there must also be emphasis on prevention and holistic care. Shifting the focus from treating illnesses to addressing the social determinants that contribute to poor health, the LHINs can strive towards improving the overall well-being of the communities they serve.

The Aboriginal Health Policy for Ontario cautions that moving from a treatment approach to prevention requires promotion, education, and growing self-reliance regarding use of health services. LHINs must invest resources in these areas.

The LHIN should employ a population health approach, focusing on reducing the health disparities between aboriginal and non-aboriginal populations. As a part of its population health approach to care, the LHIN must also shift towards providing services that extend beyond the treatment of illnesses, recognizing that housing, education, food security, affordable child care, and employment are also part of a wellness-based life.

It is apparent that the LHIN does not wish to expand its services beyond providing immediate and long-term health care. Having reviewed the act, there is no mandate for the LHIN to address social health determinants, despite the fact that these factors have a significant impact upon the health and welfare of our most vulnerable populations.

Alongside the need to comprehensively address well-being, the LHIN needs to develop indicators that measure the health and well-being of the people who use its services. These measurements would demonstrate the linkages between preventive care and acute care.

Performance indicators and outcome measurements support the LHINs' obligations for accountability to the communities they serve. In addition, ONWA recommends that a culturally specific evaluation mechanism or tool be developed to measure and evaluate the unique health status and needs of aboriginal people. These unique indicators must be developed in collaboration with indigenous organizations and aboriginal communities.

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On point 5, addressing the aboriginal health council: Under the act, the ministry is responsible for establishing an aboriginal health council. Recently, we have made aware of the fact that there has been no progress on the establishment of the health council. Both ONWA and the Ontario Federation of Indian Friendship Centres have submitted letters to the minister requesting that the council be established. ONWA reiterates that the establishment of the aboriginal health council is only an initial step towards responding to the health care crisis that continues to severely impact the lives of many aboriginal women.

As Canada's first peoples, our lives have been shaped by the experiences of our ancestors. As a people, we are still healing from the impacts of colonialism; residential schools; forced enfranchisement; loss of language, culture and lands; the high rates of missing and murdered indigenous women and girls; and aboriginal women's differential treatment under the Indian Act. The establishment of the aboriginal health council speaks to our need to gather our experiences, share our knowledge and advocate for the changes that we need to see in order for aboriginal women to feel safe accessing our health care systems.

In the end, ONWA's recommendations are:

- that the act mandate the LHINs to engage with aboriginal communities and receive advice about local aboriginal health needs and priorities. Currently, there are seven aboriginal advisory committees within the 14 LHINs, of which the North West LHIN is one that has an aboriginal advisory committee;

- each LHIN must establish systems for direct engagement with aboriginal women. ONWA must be assured an allotted seat on all aboriginal advisory councils within any LHIN in which they are established;

- as outlined in section 14(3) of the act, the ministry must establish an aboriginal health council. It is impera-

tive that the council be established immediately to ensure that the needs and unique voices of aboriginal peoples across the province are represented;

- LHINs should be required to work with aboriginal communities and indigenous populations to ensure that culture-based service options are available for aboriginal people across the province, and that these services are evaluated with a culturally specific evaluation mechanism to demonstrate success or signal the need for change—

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Kezia Picard: —Introducing an aboriginal-specific health data identifier to track ongoing service utilization by all aboriginal people would facilitate evidence-based planning;

- the focus of the LHINs must shift from an acute-care approach to a population-based approach, based on culturally specific aboriginal models;

- recognizing that 80% of aboriginal people live off-reserve, each LHIN board of directors should have one mandated seat for a community-selected member of the urban aboriginal community; and

- the act should be amended to ensure that the LHINs prioritize supports and services for mental health and addictions issues.

ONWA recommends that the LHINs develop a system that is founded upon the delivery of community-based services that are informed by the determinants of health that are developed through collaboration with aboriginal organizations and communities that are efficient, coordinated and culture-based. We again thank the Standing Committee on Social Policy for the opportunity to present and we look forward to further invitations to engage and sit on the health council.

The Chair (Mr. Ernie Hardeman): Thank you very much, and very well done on the timing. Sorry I interrupted you, or you would have been just under. So thank you very much for your presentation. It's very much appreciated.

Dr. Kezia Picard: Thanks.

The Chair (Mr. Ernie Hardeman): And we do look forward to the opportunity to give you this opportunity again. Thank you.

Dr. Kezia Picard: Thank you.

THUNDER BAY HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presentation is the Thunder Bay Health Coalition: Jules Tupker, co-chair. Thank you very much for joining us this morning. As with the other deputants, you get a 15-minute time slot. You can use any or all of that in your presentation. If you have some time left at the end, we will have some questions and comments from the committee.

With that, thank you very much for being here. The next 15 minutes are yours.

Mr. Jules Tupker: Thank you very much. My name is Jules Tupker and I am a co-chair of the Thunder Bay Health Coalition. The Thunder Bay Health Coalition is a

public advocacy, non-partisan organization made up of community groups, individuals and unions who are committed to maintaining and enhancing our publicly funded, publicly administered health care system. We work to honour and strengthen the principles of the Canada Health Act and medicare. The Thunder Bay Health Coalition is affiliated with the Ontario Health Coalition.

I find it quite interesting to be here today eight years—almost to the day—after I presented to this committee with regard to Bill 36 on February 2, 2006, raising some of the same concerns now as I had then.

The first concern I raised in my presentation in 2006 was that of the myth of control over issues facing northwestern Ontario being given to the citizens of northwestern Ontario through our own LHIN. In that presentation, I raised concerns over the language in sections 3, 7, 8 and 18 of Bill 36 that led me to believe that the government in Toronto maintained control over the appointment of the board of directors, the designation of the Chair, the remuneration of the board and the signing by the board to an accountability agreement with the government that would ensure the board would abide by the government's wishes. What I see today is that our local LHIN has put into place numerous initiatives and procedures that originated with the ministry in Toronto, leaving me with the question of why we have a highly paid group of people in Thunder Bay just passing on what was ordered not in northwestern Ontario, but in Toronto. I don't work in the health care field, but I have to wonder if the introduction of the LHINs is any better than the health council system that it replaced in providing efficient health care in northwestern Ontario.

Through our affiliation with the Ontario Health Coalition, the Thunder Bay Health Coalition has been able to keep abreast of issues surrounding possible hospital closures and/or the transfers of hospital services to independent health facilities. We know that these transfers are happening in southern Ontario, but we are unaware at this point of any anticipated closures or service transfers in the northwest. We would expect that, because of the vast distances between communities in the northwest, closures or transfers would not be planned, but if it is happening in southern Ontario, it can happen here under orders from the ministry in Toronto. These closures and transfers have been opposed by many citizens in the respective areas; however, they have taken place nonetheless, leaving us to question if public input into local health care issues really is a part of the LHIN's mandate.

To the general public, "integration" is understood to mean coordination or a combining of services. Under the Local Health System Integration Act, however, "integration" is defined in such a way as to give extraordinary powers to the LHINs and the Minister of Health to order closures, amalgamations and mergers, or even total dissolution of health care provider entities. These are extraordinary powers that did not exist prior to the LHINs legislation. The protections offered in the LHINs

legislation for public input and an open public process in decision-making are too unclear and too limited.

In 2012, the Ministry of Health approved the decision to close the Thunder Bay Interim Long Term Care home, a 65-bed facility in Thunder Bay owned by Revera, a private for-profit company. In this closure, the faults in the planning process and the total inability of the public to access information that should have been in the public domain became very clear. The public was never properly informed of who made the decision to close the beds or for what reason. Sound process, including public consultation and the ability for the public to make written submissions, was ignored. The impact on the Integrated Health Service Plan for the North West LHIN was either improperly assessed, or that assessment was ignored.

Thunder Bay could not afford to lose 65 long-term-care beds. The need for these beds was and still is simply too great. In 2012, when the beds were closed, Ministry of Health data showed that there were more than 400 people on waiting lists for long-term-care placements in this region, and residents requiring long-term care faced the longest waits in Ontario. The public relations message from the LHIN about the bed closures focused on the "interim" nature of the licence of these beds. This is a technocratic response that does not address the very real human suffering caused by the upheaval of bed closures and long waits in this community. Since the opening of the new centre of excellence in long-term care, CEISS, is delayed until at least 2015, why would the interim beds have been closed without any replacement beds being made available? The new CEISS building will add a very small number of beds—20, as far as we know—to the overall total of long-term-care beds in Thunder Bay.

With our parent organization, the Ontario Health Coalition, we wrote to the North West LHIN seeking information about the closure. They informed us that they did not consider the decision to close a health service provider and cease its operations an "integration decision" under the Local Health System Integration Act, 2006. However, under section 26(1) of the definitions, such a decision is clearly an "integration decision," which requires a set of processes. We believe that the public had the right to know who proposed to close these beds and why. The LHIN claimed it was the Ministry of Health in Toronto that made the decision; however, they did not answer any other key questions that we had about the decision. They did not answer our question about what facts or information were the basis for this decision. They did not provide us with the documents we requested comprising the approval to close the beds.

Under the LHIN legislation, section 26(3), the public may be provided with notice about the integration decision and be given 30 days to make written submissions. Note: The language of the legislation says that the public "may" be provided with this notice and opportunity to give input. This is inadequate. The Ontario Ombudsman made very strong recommendations that LHINs improve their public consultation practices. In the case of

the TBI closure in Thunder Bay, there was no notice given to the public prior to the finalization of this decision. There was no opportunity for public input. From our discussions with residents, families and community members, no one impacted by the decision to close these beds was consulted, nor was anyone given 30 days to send in their concerns in writing.

We asked the LHIN to provide any documents showing when and how public notice was given prior to the finalization of the decision to close beds, as well as any documents informing the community that they had the right to make written submissions. We also asked them to provide any documents that outlined the consultation process regarding this integration decision. They did not provide us with any of these.

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Further, under the LHIN legislation, section 16(6), the health service provider—in this case, Revera—was required to engage the affected community when making plans for the closure. We have not been able to find a single instance in which this was done. We asked the LHIN to provide any documents that showed that the LHIN required Revera to live up to this obligation under the act and any documents that related to Revera's consultation with the affected community. They did not do so.

Additionally, under the LHIN legislation, section 26(7), any integration decision by the LHIN or by the Minister of Health—that's section 27(7)—must comply with the integrated health service plan for the region. According to the North West LHIN's integrated health services plan, access to long-term-care homes is listed as a core priority, as is reducing the alternate-level-of-care problem, which is dependent on improving the supply of long-term-care beds. According to the local health services integration plan, "The North West LHIN has the longest wait time to LTC"—long-term-care—"placement of any LHIN ... and is the third highest for patients on the LTC wait-list per capita."

We asked the LHIN to provide us with any documents showing their evaluation of the proposal to close the 65 TBI long-term-care beds and its impact on the excessive wait-lists for long-term care in our region, as well as how it complies with the stated priorities in the LHIN's integrated health services plan. They did not provide us any of this information.

Finally, we asked to receive a copy of the licence agreements with Revera to operate these beds. They did not provide this.

In addition to the request for information by the Ontario Health Coalition, the Thunder Bay Health Coalition, with the Service Employees International Union, met with the Minister of Northern Development and Mines, Michael Gravelle, and MPP Bill Mauro to raise concerns over the closure of TBI and again asked these two members of the governing Liberal Party to have our questions answered concerning the closure. A letter was sent from Minister Gravelle to the Minister of Health and the CEO of the North West LHIN, Laura Kokocinski. To

this date, neither the SEIU nor our coalition has received a response from either person.

The issues we have raised here illuminate the problems that we see with LHIN processes, and we believe these problems need to be corrected:

—Key decisions about health services are made in an undemocratic fashion without public access to information.

—Health planning bears little, if any, relation to assessed needs of the community.

—The focus on integration, meaning mergers and restructuring, has overtaken key planning functions so that basic health care planning—that is, measuring and trying to meet population need for services—is not done. We wonder if there has been a proper capacity assessment done on how many hospital beds, long-term-care beds, primary health care services and health care services are needed in each of the LHIN's five health link areas. To the best of our knowledge, the hospital and long-term-care bed capacity plans were done in the early to mid-1990s. Under the LHINs, there appears to be no logical attempt to meet community needs for care.

—The LHINs do not follow their own process for integration decisions; that is, providing public notice and enabling public input.

—Vital documents pertaining to health planning decisions in the LHINs are very difficult, if possible at all, to access by the public.

In general, we feel the North West LHIN needs to become more open to the public in its decision-making and more accessible to questions by the public about decisions made concerning health care in the northwest.

Thank you for your time and interest.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have six minutes left, so we have three minutes for each caucus, starting with the third party. Ms. Gélinas.

M^{me} France Gélinas: Thank you so much for your presentation. You made it clear that you went through quite a bit of time, effort and energy to try to communicate with your LHIN about questions that are within their mandate and came out completely empty-handed and still are waiting for those answers to those questions.

If you had to choose one, what would you like to see change? Do you want change at the local level, or do you want change at the provincial level? If you were to decide, what would you do?

Mr. Jules Tupker: The initial intent, of course, the idea of the LHINs, when it was first introduced back in 2005 or 2006, was a great idea. Somebody within Thunder Bay, within northwestern Ontario, making decisions for northwestern Ontario is really important.

I come from a union background, and decisions with CUPE are made in Toronto. They have a different effect in southern Ontario than they do in northwestern Ontario.

You've heard many presentations today about the distinct issues facing northwestern Ontario. The idea of having a LHIN that makes decisions that bear on the health care of northwestern Ontario is phenomenal.

I don't think that is happening. I think it does happen to a fair extent, but I think there are a lot of decisions made in southern Ontario that the northern Ontario LHIN has to abide by but don't fit.

M^{me} France G  linas: We've heard about clarity of roles, to really clarify what it is that the LHIN does and what it is that the ministry does so that it would be clear. Would that help?

Mr. Jules Tupker: Yes, absolutely.

The Chair (Mr. Ernie Hardeman): Okay, that concludes. Ms. Jaczek?

Ms. Helena Jaczek: Thank you for coming in and providing us with an example of where you felt clearly the communication just was not working at all. Obviously, we're working at the legislation here. Is it more that you see that we need to improve—I guess this is picking up from Ms. G  linas—sort of the clarity of the roles? Is it the way the legislation is being implemented locally that you feel is at fault? The intention, as I read the act, is to foster communication, to open channels. How do you see us moving forward? How do you see us taking what you're telling us and somehow ensuring that the communication and the explanations and all the public consultation is actually taking place?

Mr. Jules Tupker: I don't know. The language in the legislation is quite clear, that there has to be public consultation.

From what I understand—and again, I'm not in a health care field—there is communication with the institutions that provide health care. That seems to be the LHIN's interpretation of dealing with the public. I'm a member of the public. I'm involved with the health coalition; I'm involved with a number of other organizations—injured workers, the elder abuse committees in Thunder Bay. I don't know anything that goes on. There's nothing in the paper about consultations with the public. I think that's what has to be brought forward to the LHINs, either Toronto or the LHINs—they've probably heard it today—that they have to expand and try to get the public involved in these decisions, not the people that provide the services but the people that are receiving the services. I think that's important.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. My question is very similar to the ones that you've heard already about the clarification of roles. I think you have some general problems in accessing information and some specific ones that you've really tried, through members, to get that information. Where do you think the problem really lies? Is it with the LHINs themselves or is it with the ministry?

Mr. Jules Tupker: Well, good question. We have sent letters to the LHINs themselves. As I said, we sent it to the CEO of the LHINs and we haven't even received a response. That's troubling. Is that from Toronto? I'm assuming it is. That's the local LHIN's issue, and it's very disappointing because I know they work very hard

at doing what they do. But they've ignored me. The fact is that maybe I'm just a Joe Public and I don't really have any influence in the health care field, so maybe they don't feel it's important that they get back to me because it doesn't really matter if I know what's going on. That's just the feeling that I get, and the people that I associate with feel that—"You're just Joe Public. Don't worry; we know what's best for the health care system because we are in the health care system, and we'll let you know what decisions we make. We know what we're doing, anyway."

I can't speak for the other LHINs; I can just speak for our LHIN. I'm assuming that—I don't know; it might be a government mandate to not let the public know: "We don't want to know, actually, what people think, just what our own people involved in health care think."

Mrs. Christine Elliott: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

KENORA CHIEFS ADVISORY

The Chair (Mr. Ernie Hardeman): Our next presenter is the Kenora Chiefs Advisory: Joe Barnes, executive director. Good morning, and thank you very much for joining us this morning.

You have 15 minutes to make your presentation. You can use all or any of that time for your presentation. If there's any time left at the end of it, we will have questions and comments from our committee. If not, they're your 15 minutes, so we want to hear your presentation. Thank you.

Mr. Joe Barnes: I'd like to thank you for the opportunity to come here and present to you today. First, I want to make it clear that I do not speak for First Nations or for any First Nation people. I speak for our organization only, which is the Kenora Chiefs Advisory.

Kenora Chiefs Advisory is a fully accredited organization which has received the highest level of accreditation from Accreditation Canada. Our mandate is to provide programs and services to our First Nations in the fields of health and social services. Our board of directors are the seven First Nations chiefs from our member communities.

The funding that we receive from our LHIN is mental health and addiction program dollars. We provide mental health and addiction counselling services to 14 First Nation communities in northwestern Ontario, with the distance between the most easterly and most westerly communities being four and a half hours.

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Besides delivering counselling services, we have a crisis response team that goes to our communities and helps them through a crisis situation. From June of this year to December of this year, we responded to 61 crises in 14 communities—everything from suicides to murder.

Our organization needs to work with other groups. We held a Silos to Solutions forum where mental health service providers, hospitals, police forces and advocacy groups came together to create linkages, share best

practices and develop formal inter-organizational procedures and protocols which will guide front-line workers when sharing clients and resources. Over 50 people attended this event in Kenora.

Another program that we're funded for from the LHIN is an aboriginal diabetes education and healthy living program. This program is delivered to seven of our First Nations member communities by a registered dietitian and a certified diabetes educator, who work closely with the community aboriginal diabetes initiative workers, health directors, schools and daycares to address the needs specific to each community. Diabetes is an epidemic in our communities, which we need to bring under control and work on developing more preventive programming for.

Our organization held a diabetes strategic planning session where front-line workers, dietitians, hospital staff, pharmaceutical companies and a prevention specialist came together to develop working relationships and share best practices. This group continues to work together. They have created a Kenora diabetes directory and held a Kenora World Diabetes Day Health Fair and a Kenora Diabetes Expo.

The third program that we get funded from the LHIN is a long-term-care program. We provide support services and training to our member communities for their community home support and home maintenance programming. Our goal is to have individuals receive services and care at home to enable them to live in their communities for as long as possible. We also work with our local hospitals and community care access centres to ensure proper discharge planning and outpatient services are being provided to our community members. This has been an ongoing challenge, and we have had instances where the oversight of the coordination of these services has put our clients at risk.

Our organization continues to advocate for quality health care services for elders in their communities. We are holding elder abuse awareness workshops in our member communities. We have been meeting with our communities, our local hospital and CCAC to improve discharge planning and after-care services. We have developed a strategy for supportive housing and a First Nations long-term-care facility. Unfortunately, we are being challenged with existing government jurisdictional issues, which are preventing us from moving forward with this initiative.

Our organization has identified a fragmented health care service system for our community members. The only way to improve the system is to create partnerships, integrate services and develop a continuum of quality health care services closer to home. This will ultimately improve client care and improve the overall health status of our First Nations community members.

We will not achieve our goal without the support and partnership of our local LHIN. LHIN 14 has been working closely with us since the establishment of the LHINs, and we would not have been able to achieve what we have to date without our partnership with LHINs.

The Local Health System Integration Act, clause 16(4)(a), requires each LHIN to engage the aboriginal or First Nations health planning entity in their geographical region. For the Kenora Chiefs Advisory, the LHIN 14 board of directors, executive director and senior staff have met with the KCA board and our chiefs at our every request.

The executive director and senior staff have participated in our health forums that I just mentioned, and have worked with us on developing strategies for service integration and partnerships. When we are challenged with an issue from other providers or resistance for partnerships, the LHIN has been proactive to bring us all together to work on strategies to resolve the issues in partnership.

LHIN 14 has invited us to be on every working group within their system, and we sit on the integrated leadership council of the LHIN. As the executive director, I feel that LHIN 14's management and staff are dedicated and have made every attempt to work in partnership with our organization on health planning.

The local health integration act's clause 13(3)(b) requires the LHINs to submit an annual report, which must include specific information, including data specific to aboriginal health issues addressed by the local health integration network.

The Kenora Chiefs Advisory board of directors know that having accurate health data is a critical part of developing health services. The Kenora Chiefs Advisory has developed a First Nations client registry, and is working with Health Canada, Canada Health Infoway, the Ministry of Health and Long-Term Care, eHealth Ontario, Cancer Care Ontario, the Ministry of Aboriginal Affairs, the privacy commissioner's office, the Institute for Clinical Evaluative Sciences and LHIN 14 to develop interoperability with provincial registries, and to develop data-sharing agreements specific to First Nations health.

The LHIN 14 senior staff participate on the working groups for this project and contribute their knowledge and expertise in the development of the registry. This registry will assist us to ensure that we have accurate First Nation health statistics, which will enable us to prioritize and plan health services to meet the needs of our community members.

The LHIN working with Kenora Chiefs Advisory on the First Nation client registry will ensure that the LHINs are informed of the policies and procedures developed in this project around sharing and collecting of First-Nation-specific health data and a means to do so.

There is a lot of work still to be done and many barriers that still need to be addressed in order to develop a continuum of quality health care services to the Kenora Chiefs Advisory member communities. One of the barriers that we will have to work on is that the LHIN is only responsible for a fraction of the health services in the delivery system. We need to advocate for LHINs to hold the entire health portfolio of the province.

Another barrier is that someone in the system does not have a full understanding of the challenges that we face

as service providers in northwestern Ontario. If this someone did, we would not be requested to look at saving money in the system. We would be given more to meet the true needs of the population we serve.

There is also a challenge of the numbers game, such as how many clients served. The number of clients seen is often the measure for funding allocations. In our organization, it's about holistic, culturally appropriate, culturally safe health care services being delivered to members in their communities. We take the time required to provide these services to individuals and families. We cannot, and will not, fast-track clients through our care to play the numbers game. We need to figure out a system to allocate funding to meet the needs of clients and not to match the numbers game set out by existing policies.

Last but not least, we need to measure the social determinants of health specific to our communities within northwestern Ontario and work with ministries to improve the quality of life for all. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about six and a half minutes left. We will start with the government side: Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in. We've heard from a lot of First Nations, aboriginal organizations. I know you speak just for yours. So I'd like to just delve in a little bit more to your issue around the community care access centres. On your second page, you've said, "This has been an ongoing challenge, and we have had instances where the oversight of the co-ordination of these services has put clients at risk." Could you just expand on what you mean there?

Mr. Joe Barnes: We've had situations where clients have been discharged to our First Nation communities without a proper care plan put in place, with the assumption that services exist at the community level to look after these clients. That has happened quite a few times.

Ms. Helena Jaczek: I see. We also heard from the Fort Frances Tribal Area Health Services, and they had a comment related to the CCAC that there was an assessment done for each client rather than coming in and seeing—in their time, it was sort of 15 people that they needed assessed.

Mr. Joe Barnes: Well, as you can well appreciate, client rapport is very important to client care. If you have five or six different nursing organizations delivering client care to one individual, you don't have time to create that trust, that rapport, with the client.

I can't speak for Fort Frances Tribal Health, but I know them very well. The system would be better off if they were the ones that delivered the system continually. Instead of four or five nurses, you have one nursing system—one system to develop care and rapport with clients.

Ms. Helena Jaczek: Okay. That's great. Thank you.

Mr. Joe Barnes: And I think Elinor Chaplin did a review—

Ms. Helena Jaczek: Elinor Caplan, yes.

Mr. Joe Barnes: Caplan, yes—did a review on the contracts with the CCAC and—

Ms. Helena Jaczek: There was a review, absolutely.

Mr. Joe Barnes:—procurement. Yes.

Ms. Helena Jaczek: Okay. So a change, a little bit, in the model of how the service is delivered, specifically when it's very important to have that continuity and the understanding of the culture.

Mr. Joe Barnes: That's right.

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): Thank you very much. The official opposition: Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Barnes. I'm really interested in the concept of the First Nation client registry. Is that something that's relatively new? And do you know if any of the other organizations or any other LHINs are participating in that in Ontario?

Mr. Joe Barnes: Just the LHIN 14 is participating. The concept is developing a model for all First Nations across Canada. Our organization is actually working with AFN and all the partners I've listed. We're developing a model at a small scale, but it's to be shared across the country.

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Mrs. Christine Elliott: And you've got a number of partners that are working with it. This was an initiative that your organization started?

Mr. Joe Barnes: No, it was an initiative that AFN started, and they were not able to secure funding for ongoing development. Our chiefs were able to meet with LHINs, the Ministry of Aboriginal Affairs and Health Canada, and they all contributed funding to make it go. Now it's part of the HSIF project, which is the Health Services Integration Fund from Health Canada.

Mrs. Christine Elliott: Well, it's a great initiative, because you do need to have the data to improve the system, so congratulations. I hope things continue to go well.

Mr. Joe Barnes: We have a little hiccup with eHealth Ontario because they don't have their—

Mrs. Christine Elliott: There are many hiccups with eHealth Ontario, unfortunately.

Mr. Joe Barnes: They don't have their registry in Ontario. Develop that—and they're doing an internal review so that it's following the proper PHIPA requirements, the protection of personal information act.

Mrs. Christine Elliott: I wish you well with it.

Mr. Joe Barnes: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^{me} France Gélinas: I want to come to the conclusion of your report, that for you, as we're reviewing the LHIN act, you see that the mandates of the LHIN should be brought in to include—and you say the entire health portfolio of the province, so that's primary care in health units and everything else that is presently still with the Ministry of Health: You see this would be better if it would be with your LHIN?

Mr. Joe Barnes: Yes, absolutely.

M^{me} France Gélinas: Okay.

Mr. Joe Barnes: It's a long way from Kenora to Toronto, and if we can deal a little bit locally, it's only a five-and-a-half-hour drive instead of 24 hours, and we can start planning together for all of it.

When you're integrating partnerships and relationships with other providers, if they're funded or resourced from another sector of the system, they tend not to want to sit at those tables.

M^{me} France Gélinas: Yes. You also end by saying, "Last, but not least ... the social determinants of health...." Do you feel right now that the planning of your LHIN does not take into account the social determinants of health, but stays specific to the acute care needs?

Mr. Joe Barnes: They're looking at the social determinants of health, but we're not doing enough around sharing what we're learning today to the other ministries and how we work together with those ministries. Especially with our First Nations communities that we service as Kenora Chiefs Advisory, we have a lot of social determinants in health that have to be dealt with. If we were trying to keep people in the community longer, how are we going to do that if our housing is inadequate, or if there are jurisdictional issues where we're trying to develop long-term-care facilities, and federal or provincial governments aren't decisive on whose jurisdiction that is?

M^{me} France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

Mr. Joe Barnes: You're welcome. Thank you.

The Chair (Mr. Ernie Hardeman): That brings us to the end of the presentations for today in Thunder Bay. We want to thank all the participants who were part of it.

I just wanted to point out that lunch will be in the Odin Room, before we leave the great city of Thunder Bay.

With that, if there are no further comments or questions—oh, I did have a couple of things here I needed to bring up for the committee's information.

On Tuesday, February 18, we will be continuing the report writing of diluted chemotherapy drugs. I just wanted to make sure that the committee knew about that.

On Monday the 24th—that's for this committee—we're scheduling the GTA LHINs for 50-minute slots. We also have the Ontario Hospital Association, the Ontario Association of Community Care Access Centres, and the Canadian Mental Health Association. The staff is scheduling in, so hopefully when we get back to Toronto and when the House comes back, we will be immediately—what do they say, "Hit the ground running." We will have programming in place so that we can have our meetings. Then there are some other issues that we'll need to deal with for further scheduling more information as we move forward with it.

With that, the committee stands adjourned to reconvene next week in Champlain.

The committee adjourned at 1157.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Monday 10 February 2014

Journal des débats (Hansard)

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Standing Committee on Social Policy

Local Health System
Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local



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Monday 10 February 2014

Lundi 10 février 2014

The committee met at 0900 in the Vankleek Hill Community Centre, Vankleek Hill.

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. Welcome to the social policy meeting in Vankleek Hill. It's great to be here. We're doing the public consultation on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act. This is our seventh day and the eighth city to be in. This may not be the largest of the cities we've visited, but in fact it is one of the most populated when it comes to people who want to present to our hearing, so we want to thank the Champlain township people for having that distinction. Thank you very much for being here. It may also be one of the least large cities I've ever had a public committee come to to hold a meeting, and we very much appreciate doing that. I come from a village smaller than this one, so it's nice to be here.

DR. ROBERT CUSHMAN

The Chair (Mr. Ernie Hardeman): Our first presentation is from Robert Cushman, the former CEO of the Champlain LHIN. Dr. Cushman, thank you very much for being here and taking the time to come and talk to us. You will have 15 minutes to make your presentation. You can use all or any of that for the presentation. If there's any time left, we'll have questions from the committee. With that, the next 15 minutes are yours.

Dr. Robert Cushman: Thank you, Chair Hardeman. Bonjour tout le monde. Thanks for having me. It's an honour to be here as the inaugural CEO of this particular LHIN. I came at it with a passion, and I saw what this LHIN did, and I'm very proud to have been part of that enterprise. But I did see some of the shortcomings in terms of what needs to be done with respect to the sustainability and the quality of health care in the province of Ontario.

To me, the first question is, is regionalization important? Ontario stretches from Kenora to Hawkesbury, which is not far from here. Mr. Chair, you alluded to the fact that this is a small town. Ontario is extremely big, but really, when it comes to health care, we are very

Toronto-centric. Stephen Leacock said a hundred years ago that Toronto had electricity and the rest of us get coal. I would say to you that it's very similar in health care. I'm delighted to see that most of you are not from downtown Toronto.

That's my principal point: Ontario really defies its size and population. It's not really the place to deliver and monitor health care services. Certainly, the rules of the game can be made from downtown Toronto—the standards set, the resource distribution thought about.

I'll just give you a few examples. When the LHINs started, the downtown Toronto LHIN had the same travel budget as the North East LHIN. The subway LHIN had the same travel budget as the North East and North West LHINs, where you had to take a long flight to Toronto, where you needed Twin Otter planes and snowmobiles to get to some of the villages. It's very interesting.

The Toronto Central LHIN, when I last looked, had about 40% to 50% more of the CCAC budget than the Champlain LHIN, even though we serve the same number of people. As you look around today and you think about Renfrew county and eastern counties, it's pretty clear to me that a lot of time is lost when you go to serve people, just in terms of your travel.

I just make those points to say that it underscores how Toronto-centric health care services are in Ontario, and that we really need regionalization. Decisions need to be made at the regional and local levels and by the people whose lives are affected. I think it's a key principle. Someone drew the lines on the map over a hundred years ago, for Ontario, and that's what we have and it's wonderful, but in terms of delivering services, to have that local autonomy, obviously, within the greater game plan, which you folks decide on, is very important.

Then we get to the question of, what's too much bureaucracy? I would say that the Ministry of Health, unfortunately, does not have the expertise, does not have the confidence of folks in the field, province-wide, and certainly does not have the knowledge. There's a sad fact about the Ministry of Health when you're in the health care business: It's competing with the health care organizations in Toronto, so in terms of status, money and excitement of employment, I don't think it really gets the best of breed compared to UHN or Toronto SickKids in terms of health care administrators—a fact, probably one we don't like, but the truth. This is why we really need to have regionalization. As I said before, the allocations, all

these things—there are some decisions that should be made.

The Brits have a concept: They say to decentralize when you can, at all possibility, and centralize when absolutely normal. This also applies to Ontario.

We here in the Champlain LHIN are about 98% sufficient in terms of our health care services, so you wouldn't expect lung transplants or sophisticated services that Toronto SickKids can offer to be done here. On the other hand, we also have an import business here. We serve the two neighbouring LHINs. We serve the north, and we serve Quebec. So we are very, very self-sufficient.

The Champlain LHIN, in fact, makes sense. If you compared the Champlain LHIN to the other provinces in Canada in terms of population and resources and quality and sophistication of health care services, I think we would be the fifth province, which is very telling, very interesting. Again, that speaks to the size of Ontario.

There's a lot of talk about added bureaucracy. If you're really looking for bureaucratic savings—I'm very impressed by the LHIN, frankly. I'm now working with Health Canada. I've looked at hospital administration. I'm very impressed by value for money from the LHIN. If you're really looking for health care savings, I would suggest you start at the Hepburn Block. I would also suggest that you look at hospital administration—if you compare what people are being paid there and some of the activities that are going on. I have some very close family members who work at some of the larger hospitals in the area, and in terms of value for money, if you really want to trim bureaucracy, the LHIN is not the place to start.

The second issue is, what kind of governance is needed? We were told right from the start that the LHINs would have an uphill struggle if the boards were not dealt with. The true regional health authorities got rid of the organizational boards, and we were told that we would have trouble.

I turn back to the biography of the late Fraser Mustard, a pioneer in health and early child care. In 1974, in the final report of his Health Planning Task Force, he found that the hospital boards all “wanted to protect their turf and did not want to integrate with others, and hospital doctors had no interest in integrating with family doctors.” He learned that “highly intelligent people do not find it easy to plan something that entails the loss of their *prima donna* status.” Fraser Mustard always called it the way it was, and what he said—I guess that was 40 years ago, in 1974.

In the Champlain LHIN, we have over 200 boards. As Jack Kitts has said himself, when the Ottawa Hospital wants to ignore the LHIN board—maybe not on meeting wait times, something that's prescribed by the ministry and the government, but in terms of deciding whether they should have two centres for delivering babies and whether the children's hospital should do the delivery piece, along with the neonatal piece—they can get in the

way if they want to. Jack is a great guy and is very honest about this. So this is something we have to look at.

These big boards—I hate to use the word—can be bullies if they want to and the small boards are absolutely tribal in terms of how small they are and where they want to go. Integrating two very small organizations is often as challenging as integrating two very large organizations.

0910

Again, I would say to you, what kind of governance do you want? I think we need to go to a regional health authority, but I am very concerned about having nine LHIN board members being responsible for this vast area from Hawkesbury up to Deep River with a budget of over \$2 billion and 1.1 million people. I think we need population-based boards, not institution-based boards. You would actually have not only the Champlain board, but you would also have a district board—for example, in this area of eastern Ontario north of the highway you took to get here—so that you drill down to the district level. These people are not responsible for their local hospital, but they in fact are responsible for the 50,000 or 100,000 people who live there, so a population-based board as a foundation under the regional board. Again, I think governance is very important, and I think to really come to the level of a regional health authority, you have some major challenges ahead of you in terms of dealing with that.

I would say that I do sit on a hospital board. In terms of CEO searches, out west, they get their HR department to handle all but one or two of the top positions. Here we have headhunters do it. It adds an inflationary cost because we can't involve the HR department of the various hospitals or institutions. There would be major savings there.

So much of what goes on at a board is board education. One of the priorities of a board is invariably real estate, yet in the United States today, they're closing hospitals regularly because there's a big question in front of you, and that is, what needs to be done at a hospital in 2014? I would argue that if you're not on a ventilator, you may not need a hospital, which is very interesting. Yet we concentrate all of our resources in hospitals. Physicians—and I'm a physician—love it. Let me tell you, it's great. But in terms of having a patient-centred system, dealing with people—parking is very pricey, very difficult for people who are frail and pushing walkers around on the sixth floor of a parking lot in a snowbank because the final floor is exposed to the elements. This is a big issue.

My fourth point is hospitals, and I touched on that briefly: If you think about the Canadian health care system, we first started funding hospitals, and secondly we started funding physicians. We're actually in trouble because that's a World War II model. It was wonderful, but if you think of how health care has shifted into the community and how we need other resources, unfortunately in this zero-sum budget era that we live in, we're having trouble making the transfers. Again, what needs to be done at a hospital? That is a key question. As I said

earlier, experts in the field say that, really, if you're not on a ventilator, chances are it could be done someplace else, which is very interesting. Furthermore, you have these smaller hospitals when you may actually be better off in an ambulance on your way to a more sophisticated centre.

This brings me to the primary care issue in terms of urgent care, access and open hours beyond 9 to 5 business hours. Again, what's interesting is we're trying to transform primary care, yet we have more and more people going to emergency. One of the problems is physicians in their clinic don't have access to the tools they need to deliver after-hours care. When I used to go to my clinic, I used to have to press the alarm to get in. I would line up some patients. I was a robust, fairly healthy individual, but I would fear for a young woman trying to do the same thing, or even my wife. Who knows? Maybe I should have feared for myself in terms of an inner-city neighbourhood and going in to see three or four patients in an afternoon where you had to turn on the lights and deal with the alarms and open up the rooms. As one of my colleagues has said, what you actually need is a mezzanine service for these urgent care clinics, but you have to provide physicians with the material to do their work. To give five stitches, you probably need to go to a place with a big H in front of its parking lot, that type of thing; to get some basic laboratory or X-ray information—that's a clash there. You notice I said we don't need as many hospitals as we have, but from the primary care sector, we have to get some infrastructure. Whether you expropriate some of the hospital infrastructure for these after-hours urgent care centres or whether you set up some additional structures depends on where you are and what's available.

As for physicians, I said earlier that I'm one, so I tend to know my tribe pretty well; my wife is one. We tend to know the tribe. Physicians have done very well in Ontario of recent, but as I said, the primary care physicians need more access to the infrastructure. I would actually challenge you that the in-hospital specialists are doing very well these days and yet when you think about it, all the infrastructure, all the physical equipment, all the capital equipment they need is provided to them. At the university hospitals, sure, we devote time between research and teaching and service, but, still, the basic infrastructure is provided.

Just to draw an analogy, can you imagine Air Canada pilots having that amount of autonomy in terms of when they take off and where they land? This is another real issue you have to think about: that in the community, physicians are paying 30% overhead. The question is, how does that relate to hospitals? That's a tough question but it needs to be asked and you're not going to make people happy when you ask it. I may have trouble with my peer group when I leave, but I think it's something that's worth asking.

I'd just wrap up and say that I think Ontario is too big to deliver all but the basic principles and outline and funding of health care and that regionalization makes an

inordinate amount of sense. Interestingly enough, it failed in Alberta because Calgary and Edmonton had fierce competition not only in football and hockey but also in health care. Frankly, both cities thought they were as big as Vancouver or Toronto. That's what happened in Alberta. But if you look at Alberta Health Services, now they don't have regions; they have zones. Very quickly and quietly, they're realizing that there's a better way to organize health care than on the basis of that large province.

I'm a big fan of regionalization. In order to keep health care sustainable and effective in Ontario, there are a number of things you have to do, which I've outlined. It's interesting—I'll just close. I have this piece here: the nine key factors for a successful health care system. The two "A"s: accessibility and affordability. I think regions can improve accessibility. The three "E"s: effective, efficient and equity. Again, I think a region can do that. Patient-centred and integration—

The Chair (Mr. Ernie Hardeman): I hate to have to stop you there. You do have a printed presentation?

Dr. Robert Cushman: I don't, actually, but I can leave you those nine—

The Chair (Mr. Ernie Hardeman): Yes, okay, and then the committee can finish reading them. I do have to stop it right on the 15 minutes.

Dr. Robert Cushman: I'm sorry I went over a few seconds; my apologies.

The Chair (Mr. Ernie Hardeman): It's a very informative presentation, and we really do want to thank you for making it to us this morning.

Dr. Robert Cushman: My pleasure. Good luck to you. You have a big challenge.

The Chair (Mr. Ernie Hardeman): Thank you.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is Champlain Local Health Integration Network: Chantale LeClerc, chief executive officer.

Ms. Chantale LeClerc: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in and sharing your time with us this morning. As with the previous presenter, you will have 15 minutes to make your presentation. You can use any or all of your time, but, as you noticed, not more.

Ms. Chantale LeClerc: Got it.

The Chair (Mr. Ernie Hardeman): If there's any time left over at the end, we'll have some questions and comments from the panel. With that, your 15 minutes starts now.

Ms. Chantale LeClerc: Perfect. Thank you very much, and good morning, Mr. Chair and honourable members.

It's my pleasure to welcome you today to the township of Champlain in the very big region of Champlain. I'd like to thank you for providing me with this opportunity to tell you a little bit more about what the Champlain

Local Health Integration Network's role is in creating a person-centred, quality health care system—that's what we're all about—and how the Local Health System Integration Act does enable that role.

Monsieur le Président, mesdames et messieurs les députés, bienvenue dans la région de Champlain. Je vais m'adresser au comité aujourd'hui principalement en anglais, mais il me fera certainement plaisir de prendre vos questions en français à la fin de mes propos. Je vais certainement laisser des copies de mes propos ainsi que d'autres documents, et ce matériel est disponible dans les deux langues.

Although I'm the CEO of the Champlain LHIN and I've been with the organization for close to six years now, my comments today are also informed by the fact that I'm a registered nurse. Over the course of close to two decades, or more than two decades now, of working in the health care system in this province, I've had the opportunity to work in very different roles across most of the health care sectors. So my comments are informed by that foundation, which gives me some context.

0920

The Local Health System Integration Act established health networks to plan, fund and integrate health care services at the local level, and I thought that the best way to illustrate for you the power of that unique legislative mandate would be to provide you with a single example of a real live person. In this instance, it is a senior. I know that you've likely heard similar stories as you've travelled around and met with different people, but this is the fastest-growing segment of our population. It is a population that we all look after. If we get health care right for seniors, there's a very good chance we will get it right for many other people as well.

I'm going to talk to you about Mrs. Smith, but you can think of an older person that you know—it could be your mother, your father or a next-door neighbour—and I'm quite convinced that their story would be very similar to hers. I've summarized Mrs. Smith's stories in the documents that I'll leave behind for you, and I've provided much more detail, but let me summarize by saying that she's an 87-year-old lady who lives alone in her own home; she has been managing very well, thank you very much, with the help of a housekeeper and a personal support worker that she gets through the community care access centre. She manages her daily activities. She's able to socialize with her friends. She gets out of the house using our transportation system, and she is visited by her daughter. But, lately, she has been becoming increasingly confused. She is incontinent of urine all of a sudden, and she ends up visiting the emergency department because she's dehydrated and she's no longer managing. It's a story you've all heard many times before.

She does get admitted to hospital, and while she's there, her condition continues to deteriorate. Now she has become alternate-level-of-care. Her acute phase of hospitalization is now complete and she needs to be transitioned to a different setting. Everybody—her health

care providers, her daughter—now thinks that because she continues to be confused, it's in her best interest to apply for a long-term-care home. So papers are put in, and she will likely sit in the hospital waiting for several months, with her condition continuing to deteriorate, for that placement in the long-term-care home.

When the LHINs arrived on the scene, in this region, 15.8% of all hospital days were occupied by people like Mrs. Smith. More than half of those individuals were en route to a long-term-care home; in fact, two thirds of all admissions to long-term-care homes in this region were via the hospital and not the community, where they should be from. We had 3,000 people on the waiting list for long-term-care homes. People were waiting close to 37 hours in emergency departments, waiting for a bed on a unit when they needed to be admitted. Elective surgeries were being cancelled on a routine basis. This was very much a system in crisis, and this was a symptom of what was going wrong with the health care system.

Today, if you fast-forward a few years, because of the work of the Champlain LHIN and our many partners, the story is very, very different. I'm extremely proud to say that we've been moving a whole system, because ALC is a symptom; it's not the cause.

Today, Mrs. Smith would benefit from a whole host of new initiatives and different ways—we've actually transformed the way services are being delivered for seniors. So she would have access to services that would have kept her healthy in her community in the first place, which would have intervened quickly when things started to go wrong. Someone would have diagnosed a urinary tract infection as the cause of her change in behaviour, and that would have been treated. She would have been helped to avoid a visit to the emergency department or an admission to hospital. Then, if she did need to be admitted, she would have been transitioned home with appropriate services much more quickly.

Today, 13% of hospital beds, compared to 15.8%, are occupied by people like Mrs. Smith. What's more, these individuals are transitioned back to their community 11 days sooner. That's the equivalent of opening up 65 more acute care beds in our region, and that has made a huge difference. Roughly now 10% of people who are in hospital are going to long-term-care homes as opposed to the 53% that it was several years ago. That is incredibly significant in terms of a change.

Wait times in emergency rooms for people who are waiting for a bed on the unit have been reduced by 11.7 days, so that's a 32% improvement, and we rarely hear now about elective surgeries being cancelled because there isn't a bed for a person post-operatively. So the data is showing that we're making a difference, and we know we are making a difference because we're hearing about it. We do know that the situation is dramatically different and we've been able to reverse a worrisome trend that was occurring. We know that things are working much more seamlessly for people like Mrs. Smith. I know that this would not have been possible without the LHIN's interventions and I know this because health service

providers, hospitals, regional offices of the Ministry of Health and Long-Term Care, district health councils—many others were at this long before us, and no one had been successful up until now at producing the kind of health care system that provides the right care at the right time at the right place for the right cost.

In Champlain, how did we accomplish this? We looked at data. We started with evidence and we brought that evidence to the table so that people could be working from a fact-based platform and not from anecdotes, but we also spoke to many people. We spoke to health service providers. We spoke to seniors, more importantly, and we spoke to many other partners about what was working well and what wasn't. We brought people together to develop solutions. We mobilized champions to produce the kind of change we were looking for in this region. We broke down silos, but always, we kept Mrs. Smith's story first and at the very front and centre. We used our local knowledge to make strategic investments. We know where to place the investments to make the biggest difference. We actually cancelled programs that weren't producing results and we reinvested the funds in those that were. We held providers accountable for the kind of results that seniors were expecting. We leveraged technology to help provide or share information and to bring innovation solutions like video conferencing, so people didn't have to travel to appointments. We actually worked with other LHINs in the province to leverage their best practices and initiatives that they had tested so that we didn't have to reinvent the wheel 14 times across the province, and we ensured that initiatives we were implementing were responsive to the needs of the very different kinds of seniors.

If Mrs. Smith was Madame Tremblay, we worked with our health planning entity to make sure that she could get services in French, and you'll hear more about that later. We also made sure that if Mrs. Smith was Mrs. Whiteduck, we were working with our Aboriginal Health Circle Forum to make sure that her services would be culturally appropriate.

I think this example has highlighted the role that the LHIN plays in transforming the system. We really are the only actor that has this very powerful role. It is enabled by the Local Health System Integration Act and its commitment to local governance, local planning, local decision-making, and, really, the local ability to act. We can be quite responsive to the kinds of issues we're seeing and actually take action.

While we have had, as LHINs collectively, a positive impact at moving this system forward, there are some opportunities to strengthen our roles through the legislation. You've heard about bringing primary care more closely under the purview of the LHINs. For someone like Mrs. Smith, that might have meant quicker access to her health care provider, or more ability to monitor her condition or take action before things went wrong.

Also, giving the LHINs more flexibility when it comes to funding would allow us to prevent delays in implementing initiatives and would give us some of the tools

we need to push the system forward. For Mrs. Smith, this could have meant having a new program that would have met her needs up and running much more quickly.

Finally, making sure that health service providers and their boards share in the responsibility for ensuring a high-performing system would absolutely help accelerate health system change. For someone like Mrs. Smith, this would have meant every one of the providers she interacted with feeling a collective sense of accountability to transition her home as quickly as possible, whereas sometimes we are seeing that people do not always share in that common goal.

Alors, membres honorables, merci beaucoup pour votre attention et pour la chance d'informer votre travail important. Il me fera plaisir de prendre vos questions dans la langue de votre choix.

Thank you very much for your attention. I've left some time for questions, I believe.

The Chair (Mr. Ernie Hardeman): Thank you very much. We do have just under four minutes, and we will give that to the third party. Ms. Gélinas?

M^{me} France Gélinas: Bonjour, Chantale. Comment ça va?

M^{me} Chantale LeClerc: Ça va bien, merci.

M^{me} France Gélinas: J'ai été surtout intéressée—à la toute fin de ta présentation, tu nous parles de l'intégration des soins primaires sous le rôle de ton RLISS. Dans d'autres régions, il y a beaucoup, beaucoup de réticence à faire ça, surtout à cause des joueurs locaux.

0930

Est-ce que tu penses que dans Champlain, il y a une ouverture à faire ça?

M^{me} Chantale LeClerc: Je pense que oui. On a une très bonne relation de travail avec les pourvoyeurs de santé primaire. On était capable de faire des initiatives ici qui sont très, très intéressantes.

Par exemple, j'ai des rencontres avec les équipes de santé familiale. On en a 21 dans cette région, et elles cherchent beaucoup à se rapprocher de nous. Elles voient comment on pourrait travailler ensemble pour mettre sur pied des solutions intéressantes et innovatrices dans la région. Alors, il y a certainement un peu de réticence toujours, un peu d'inquiétude quant à l'inconnu, mais il y a une ouverture à voir ce dont ça pourrait avoir l'air.

M^{me} France Gélinas: L'autre service qu'on parle parfois à amener sous la gouverne des « LHIN », c'est les bureaux de santé publique. Est-ce que c'est quelque chose que vous considéreriez?

M^{me} Chantale LeClerc: Je sais qu'il faut absolument qu'on travaille en partenariat avec les bureaux de santé publique. Dans cette région, on a des beaux exemples où on travaille très étroitement ensemble, même au niveau du partage des données; on a des initiatives conjointes.

Ça va? Est-ce que ça devrait faire partie du RLISS? C'est peut-être un peu plus compliqué, étant donné leur structure et le fait qu'ils sont aussi gouvernés par les municipalités. Alors, je ne pense pas que c'est aussi simple que la santé primaire, mais c'est quelque chose

qui mérite d'être exploré. Par contre, qu'ils soient sous nous ou non, il demeure qu'on doit travailler ensemble.

M^{me} France Gélinas: Puis le dernier, c'est au niveau des centres d'accès aux soins communautaires. On a des agences communautaires qui nous disent pour nos—maybe I'll do this one in English.

Community support services comes to us and says, "For our homemaking services, for our community services, we get funded by the LHINs, but for our home care services, we get funded by CCAC, although we serve the same person with the same goal, the same care plan. Why is it that for our community services we get funded by the LHINs, but for our home care, our professional services, we get funded by CCAC?"

Any ideas as to whether this is a good system, or should we look at something different?

Ms. Chantale LeClerc: I think it does work. In this region certainly it does work. We've been actually working very closely with the community agencies and the CCAC and the LHIN to look at how we better distinguish and differentiate roles.

I think what it comes down to is not so much on the distinction between services; it's about population. The community support service agencies are more and more looking after the least complex individuals, and the CCAC is increasingly looking after people who have much more complex needs and need care coordination and need assistance with bringing in other services to form their care plan. So I think we will see over time much less overlap between who is doing what with the same individuals. I think you'll see that the type of clients will be better oriented towards one or the other.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate your coming in and enlightening us.

Ms. Chantale LeClerc: Thank you.

CHAMPLAIN COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is Champlain Community Care Access Centre, Gilles Lanteigne, chief executive officer. Hansard will record it the right way, as opposed to the way I pronounce it. Thank you.

Dr. Gilles Lanteigne: Bonjour, Mr. Chair and honourable members of the Standing Committee on Social Policy.

Mon nom est Gilles Lanteigne, et je suis directeur général du Centre d'accès aux soins communautaires de Champlain. J'aimerais vous remercier de m'accorder cette occasion de présenter au comité permanent.

I joined the Champlain CCAC as CEO in September 2010. Over the past 30 years, I have held leadership positions in a variety of health care settings, and I've had the opportunity to work with numerous health care organizations in all provinces across Canada. I also have extensive international experience. I believe that my diverse

background provides me with a unique vantage point for identifying key challenges and opportunities.

My presentation will focus on four key questions that I believe are central to evaluating the current legislative framework in review by the standing committee:

—Are regional health planning entities such as the LHINs needed?

—Are local health integration networks meeting the obligations under the Local Health System Integration Act?

—Should the CCACs and the LHINs be merged?

—What opportunities exist for continuing to drive efficiencies in the health system?

To learn more about the Champlain CCAC and the important role of care coordination in the health system, I refer you to the supplemental information that is attached in my presentation.

I will now address the four questions.

Are regional health planning entities such as the LHINs needed? Regional health entities responsible for planning, funding and accountability have been in place in all provinces for many years. Regional planning models vary in each province, depending on the population, geography and other factors. When you consider that a region such as Champlain is larger than many Canadian provinces, with a population of close to 1.3 million and over 200 health care organizations, a LHIN, or other type of regional planning entity, is vital to meeting the local needs.

A high-functioning and sustainable health system depends on working together. To meet the needs of our clients today and in the future, all health care providers must continue working in close partnerships. The LHIN plays a vital role in fostering collaboration among providers across the health system. As such, we must reinforce the LHIN's mandate to support the critical role of long-term planning, resource allocation, capital funding and increasing collaboration among all players in the health system.

Cross-sector collaboration, supported by the LHIN, is yielding some exciting successes. Home First is just one example of how our partnership is producing important shifts in our health system's ability to ensure the right care, at the right place, at the right time.

Home First was introduced in Champlain region in 2010. At that time, the number of alternate-level-of-care—ALC—patients in the region was too high. Far too many seniors were waiting in hospital for long-term-care beds to become available. We knew there had to be a better way of meeting the needs of these patients.

Home First represents an evolution in health care thinking, and Ontario is leading the way. The philosophy is focused on keeping high-needs seniors safe in their homes for as long as possible with CCAC care and other community services. Working with the LHIN and our hospital partners, Home First has been rolled out successfully in the region. While the LHIN financially supported Home First and helped bring the partners

together, the CCAC took the lead in making it happen at the patient level—an important distinction in our roles.

From my experience in health care, Home First would have been next to impossible without the partnership with the LHIN. Indeed, results in the region are impressive. A different data point than was presented in the earlier presentation, but Home First—one data point is taken here: 55% of placements to long-term-care homes were from hospital; today, that's less than 30%. That means that, from the community, there's more than 70% of people accessing long-term care. This has freed beds: in 2013, close to 41,000 hospital days. ALC numbers have dramatically decreased. Of the patients supported to go home, 86% of these remained in the community after 90 days. Estimated conservatively, net annual savings are over \$10 million a year.

The second question: Are local health integration networks meeting their obligation under the Local Health System Integration Act? Overall, the current legislative framework is working well, and the LHIN itself is meeting the needs of our diverse communities. The LHSIA's purpose is to mandate the LHIN to provide for an integrated health system that offers quality care, effective and efficient health services for Ontarians. We know that the health care system is rapidly changing and that managing our health dollars and the planning and accountability of health service providers is more critical than ever. Services that had been offered in one part of the health system 10 years ago are now being delivered elsewhere.

In the home and community care sector, we've seen this transformation first-hand as we support more people at home with higher care needs. In Champlain, we've seen a 37% increase in chronic patients in a single year. And we're caring for more MAPLe 4 and 5 clients—that is, people with needs comparable to those in long-term-care facilities—at home. Consider this: Champlain CCAC is now caring for 6,000 higher-needs clients at home. That's the equivalent of 50 long-term-care facilities.

The scope of in-home service offerings has also expanded dramatically. Today, we're delivering services such as chemotherapy, wound care and intravenous therapy at home, all services traditionally provided in the hospital. Under the current framework, we are well positioned to continue expanding this range of services we can offer. Delivering more home care at home is not only significantly more cost-effective, it is what people want.

0940

Third, should the LHINs and the CCACs be merged? There has been some suggestion that merging LHINs and CCACs would yield efficiencies. To date, we have not seen any evidence to support this. There are many factors that must be analyzed in undertaking a structural change of this scale. I would like to offer a brief perspective based on economics, impact on services, compatibility of functions and, finally, timing and context.

First, it is important to consider the very different roles played by the LHINs and the CCACs. The LHINs plan and fund the health system, while the CCACs deliver care to patients. Merging the LHINs and the CCACs would result in a hybrid organization unlike anything that currently exists. New expertise would need to be developed, and conflicting functions such as funding allocation and accountability frameworks versus providing direct care to clients would need to be defined.

Logic might suggest that a merger would result in significant and immediate savings, at least on overhead and administrative costs. Most provinces in Canada have experimented in this area, with mixed results. Evidence demonstrates that synergy and, thus, savings are created in horizontal mergers—similar organizations, such as long-term-care home with long-term-care home, or hospital with hospital. But this isn't the case with vertical-integration mergers—organizations with different mandates.

More important than this question of cost savings is whether such a merger would improve care to patients. Again, there is no evidence for this, and in fact, we know from experience that disruption from health care restructuring can negatively impact patient care until the system is restabilized.

For these reasons, I believe that merging LHINs and CCACs would generate marginal benefits, with significant potential savings lost because of the complexity inherent in such a vertical merger. Greater efficiencies can be obtained by strengthening the LHINs and continuing to fund efficiencies through strategic partnerships, local solutions and leveraging technology.

Last, what opportunities exist for continuing to drive efficiencies in the health system? As the population ages and the complexity of care increases, we must continuously look at ways to drive efficiencies. There are a number of opportunities for maximizing health care dollars and continuing to advance quality of care.

One exciting opportunity unfolding across our region relates to technology. In partnership with the LHIN, electronic information sharing is now in place between Champlain CCAC and 165 LHIN-funded programs across 140 agencies. The power of technology is one of the most transformational elements for enabling a more effective health care system.

Another example: Our CCAC is working with Bruyère Continuing Care and leveraging our existing electronic tools to provide a single point of access to a range of palliative services. More end-of-life patients are able to die in their place of choice in Champlain than in any other region in Ontario. Similar collaboration with other partners, such as family physicians, offers numerous possibilities for realizing efficiencies.

We have made great progress in reducing the number of people waiting for a long-term-care home and increasing the number of people going to long-term care from the community instead of hospitals. We expect this trend to continue as we deepen our collaboration with the community support sector in implementing information

sharing in real time, developing joint care plans and sharing assessments.

A program introduced with paramedics in Renfrew county is a compelling example of a local solution that is both enhancing patient care and yielding cost savings. The model is simple, yet the impact is significant. When paramedics receive a call from a senior, they screen that person to determine if they're at risk for loss of independence. People at risk are referred to the CCAC for ongoing support. This dose of preventative medicine means more seniors can remain at home. Costly 911 calls from anxious seniors have been cut in half, and emergency department visits have declined. Collaboration is key in developing innovative local solutions with existing resources.

On balance, our system is responsive and meeting the needs of people in the Champlain region. Last year, our CCAC patient survey showed that over 93% reported a positive care experience. The current legislative framework allows for flexibility and supports innovation, key ingredients in any person-centred, high-functioning system of care.

Looking ahead, I'm excited by the opportunity for increasing the connection between the CCAC and primary care, optimizing best and promising clinical practices, expanding the delivery of services in the home, and continuing to unlock the technological solutions that make it easier for our clients to get the care they need close to home.

There is still much to be done, and we continue to work with our partners in advancing our vision. However, I believe that we have the right foundation for a stronger health system.

Merci, et je suis heureux de répondre à vos questions, soit en français ou en anglais.

The Chair (Mr. Ernie Hardeman): Well, thank you very much for your presentation. We have about three or three and a half minutes left, and we'll go to the government side.

Ms. Helena Jaczek: Thank you very much, Monsieur Lanteigne, for coming today, and thank you for addressing kind of the crux of the matter, what we are hearing across the province: the issue of some sort of integration between the LHIN and the CCAC.

One of the things that you said in your presentation is that the CCACs deliver care to patients. I guess that, from many people's perspective, what you actually do is you contract with other agencies to deliver care. Your employees are care coordinators, but we certainly get complaints within our constituency offices that these individuals do not do any hands-on care. They don't look at the wound when they do the assessment.

We've also heard, certainly in the North East LHIN, that some hospitals still have a position called a discharge planner.

So could you just explain yet again how the CCAC delivers direct care to patients?

Dr. Gilles Lanteigne: Well, CCACs provide direct care to patients through assessment, through care co-

ordination, through working in collaboration with primary health care physicians in doing those assessments and ensuring that the care is provided.

Now, what is not really known is that CCACs do also provide direct care. All of the care coordinators are professionals. Most of them are nurses, physiotherapists, occupational therapists or social workers. This function is—in the literature, you will see that it is considered direct care to clients.

We also have other programs; what you would call “hands-on,” as you term it, is provided by CCACs. So I'm glad that you're bringing that myth out as a question, because care coordination is recognized as bringing value, direct patient care, and is considered in the literature and in other systems as direct care.

Ms. Helena Jaczek: Do—

The Chair (Mr. Ernie Hardeman): Thank you very much. Thank you very much for your presentation. It's much appreciated.

DR. WILBERT KEON

The Chair (Mr. Ernie Hardeman): Our next presenter is Wilbert Keon.

Dr. Wilbert Keon: Thank you very much.

The Chair (Mr. Ernie Hardeman): I should say “Dr. Keon.”

Dr. Wilbert Keon: Whatever.

The Chair (Mr. Ernie Hardeman): Thank you very much. I understand that you also hold other titles, but we'll leave that all to you. I was just given the introduction as Dr. Keon.

Welcome. You will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If there are any questions or comments, we will have some questions from the committee. With that, your 15 minutes starts now.

Dr. Wilbert Keon: Okay. Thank you, honourable Chairman and honourable members. I'm delighted to be here. I am chair of the board of the LHIN, as you know, but I was asked this morning to slant my comments in a general context as an individual, and I'll try to do that. I have prepared notes that may be a little bit biased, but I'll try to be as objective as I can. I'm hoping I can make a useful contribution to your deliberations, and I will be raising a few issues that are a bit different.

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For many years, I've been a great enthusiast of regional health services and a true supporter of local governance. While the LHIN model isn't perfect yet, it's pretty close to ideal. Its strength lies in its local emphasis. The letter L in the LHIN acronym is what I plan to focus on in my remarks. We have local partnerships, local service delivery, local decision-making and, perhaps most important of all, local governance.

There's a definite need for central decision-making, of course, in health care: for overall planning, governance, coordination and capital planning. Pandemics, for example, can only be handled by centralized planning and

indeed by federal-provincial planning. But central planning must work in concert with regionalized programs. It's not an either/or situation. It's very important that the LHIN planning be in sync with Ontario's Action Plan.

The 50/50 split of finance and responsibilities seems to work for the time being, until something better comes along. Programs are divided equally: six from the LHINs and six from the province. That seems to work fairly well. There has been a tremendous amount of experimenting across the country over the past 40 years. Having been active in my career during some of that, I was distressed to observe the wheel-spinning that went on, the reinvention of the wheel, the loss of time for everybody concerned and the loss of the patients in the system, so we have to be careful not to go there. I'm a great believer in evolution and change, but we have to be careful not to just throw the baby out with the bathwater.

The great advantage of local health care governance, if we get it right, is that it helps us build healthy, productive communities. I spent a good deal of time thinking and talking about healthy, productive communities. Many of you know that, as a Canadian senator, I was privileged, in 2009, to chair the committee that examined population health and produced a report on what a healthy, productive Canada means. The report concluded that Canada is generally perceived as one of the greatest countries in the world in which to live. When it comes to health, however, we unfortunately have serious disparities.

While researching the report, we travelled to healthy communities and to unhealthy communities, noting the difference between the two. There will be a baby born tonight in the Champlain LHIN with a life expectancy of about 50. That baby will have poor health because he or she was born into a family that had poor health. Another baby born tonight to a different family will live for 100 years or more and likely be far more productive. Those are the kinds of disparities we are faced with, and we must start to think on a much broader scale than we've been doing.

The fact is, health services account for only about 25% of health outcomes. The rest is determined by the determinants of health, such as housing, education, income, transportation, etc. It is clear we are not spending enough time on the 75%. We've become preoccupied with the repair shops—and I've built a deluxe one myself along the road—of the health care system, instead of focusing on preventing disease and diminishing the need for these repairs.

What does all of this have to do with the LHIN? Without a doubt, the LHIN has all the levers necessary to enact meaningful change, not just change in the way that home care and hospitals work, but I would argue that the LHIN has the instruments in place to affect all the issues that impact on health outcomes, working in concert with other relevant players.

Health outcomes improve when seniors can enroll in falls prevention, when those with severe addictions can have proper counselling and a key to an apartment, when

people with diabetes can have foot care close to home, and when a community health care centre expands in an underserved neighbourhood. For instance, the launch of a satellite community health centre in Beachburg in Renfrew county has reduced the number of emergency room visits at Pembroke Regional Hospital.

It is important to note that the local lens is also alive and well in the work of the board of directors of this LHIN. LHIN governance is done by local members who have interests in the broader social system. We, as board members, are very much aware of the importance of developing health care in the context of the overall well-being of our citizens. Every year, in the spring, summer and fall, the Champlain board travels to various regions. Last year, we had public meetings in West Carleton, Pakenham, Cornwall, Eganville, Deep River, Chute-à-Blondeau and Ottawa. We know that each of these areas has special needs, and the citizens of these areas have an opportunity to talk to the board members and tell them how they think things can be improved for them.

Another example here is the non-urgent transportation program which the LHIN has instituted. With a combination of volunteers and LHIN-funded vans, the rides for residents were increased by 20,000 last year. You can just imagine what this does for a person who is incapacitated during an ice storm or something like that—or just to get to the grocery store.

We also have problems in the LHIN with wait times, and they have to be solved. Last year, Champlain LHIN CEO Chantale LeClerc and I met with the board chairs and the CEOs of the 20 hospitals. We said, "We have to do something. These wait times are not satisfactory. Let's look at MRI. Let's do something about it." The Ottawa Hospital stepped up and said, "We can help." They have helped, and MRI wait times have been reduced by 50% over the last year. And there are other examples where local initiatives and local governance can work.

Where do we go from here? For one thing, we need to stay the course with a regionalized health system that operates in concert with the central system. I'm pleased that health links are in concert with that philosophy and concept, and I believe they will improve things considerably.

Some people have asked me whether the LHINs should have more authority. People wonder whether the LHINs should have jurisdiction over primary care, public health and home care, and the CCAC. My answer to that question is that ownership doesn't matter. It doesn't matter who owns it. The important thing is to work together. Integration is not ownership. Instead, we can strengthen the structural framework that allows people to work together and do the best for the patients. We need to emphasize connectivity and give the front-line workers an opportunity to work together.

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You'll note I have not addressed proposed legislative changes. Your committee will receive a document suggesting 15 changes that has been prepared by the LHIN collective. I'm sure you already know that. You should

get that document today or tomorrow. I think it's in the final stages, so I'll not comment on that.

I think I have a few minutes for questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation. We do have three minutes for questions. The official opposition: Ms. Elliott.

Mrs. Christine Elliott: All right. Thank you very much, Chair, and thank you very much, Dr. Keon, for being here today. We greatly appreciate your insights. I would say—I can probably speak for the rest of the committee—that we share your concern that some of the other determinants, other than just the health services that are being provided, are important to be integrated to produce a system that's going to be focused more on wellness, on health promotion.

I'm wondering if you could give us a little bit more insight into how you would propose to do that, how you're working here in the Champlain LHIN and what else we need to do to be able to integrate that so we really have a system that's focused on healthy, productive communities.

Dr. Wilbert Keon: Right. Well, that's a very, very important concept and it's one we really must be dedicated to. I have asked our board members to involve themselves in the community, to work with the council, to work with various other agencies and so forth and see where some of the deficiencies are.

It's incredible when I mention that life expectancy—one of the fundamental indices of good health—is not the same across our LHIN. At both ends of the LHIN, we have people with very, very low life expectancies, so we've got to get out. That's why we travel as a board. The board members have to get out. I ask them, "If you're going to serve on this board, will you get out there and work at community engagement so the communities can tell us what they need, whether it's better housing, a clean water supply, clean air, whatever, to eliminate some of these things that are causing such poor health?"

Mrs. Christine Elliott: So would it be fair to say, then, that you're looking beyond traditional LHIN service providers and health groups that you would expect to be working with you and looking to the broader community, to other areas? For example, we've had several chiefs of police come to speak to us about some of the issues that they're facing, particularly with respect to mental health and addictions issues. Is that what you're looking at as well in this LHIN?

Dr. Wilbert Keon: Absolutely. And I met with the police when I was doing the Senate report. I met with the police across the country—in Vancouver, in Ottawa, in Toronto—and said, "How can the system help you with the problems you have picking up addicted people in the middle of the night and so forth?"

I believe my time is up. The Chairman has turned on his red light, and I have to run.

Mrs. Christine Elliott: Thank you very much, Dr. Keon.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Doctor. We very much appreciate it.

Dr. Wilbert Keon: Thank you.

HÔPITAL GÉNÉRAL DE HAWKESBURY AND DISTRICT GENERAL HOSPITAL INC.

The Chair (Mr. Ernie Hardeman): We now have—the next one is not coming, and then the following one is on their way, I believe. We will go to the Hawkesbury and District General Hospital, Sébastien Racine, president. He is here, so we will replace the other ones as they come in when we can.

With that, thank you very much for being here and being heard just a tad early this morning. As with all the presentations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's sufficient time left at the end, we will have some questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Sébastien Racine: All right. Thank you.

Bonjour. Mon nom est Sébastien Racine. Je suis résident de Casselman, Ontario, et architecte de profession. Je suis ici à titre de président du conseil d'administration de l'Hôpital Général de Hawkesbury et District.

In my presentation today, I will first focus on the leadership that HGH has assumed in health care integration at the local level and highlight some of the positive outcomes in Prescott-Russell. I will conclude with some reflections on the LHIN's mandate and offer considerations.

First, HGH's role as a health system partner in Prescott-Russell: The board of HGH has, for the past five years, been strongly committed to aligning the hospital's programs and services with the provincial and regional directions. The board has been engaged with other hospitals and with the LHIN to create a positive environment to build collaboration among local providers and fix the significant service gaps in Prescott-Russell. More specifically, the following hospital-led projects and initiatives demonstrate this commitment to integration.

First, our HGH redevelopment project: Our hospital infrastructure renewal and expansion project has been developed and planned in close collaboration with the LHIN, the Ottawa Hospital, our tertiary-care referral centre and other local partners, including primary care physicians. The construction of our expanded and renovated facility will start this summer. The new HGH will offer care closer to home and meet the needs of the community for the next 15 years.

Another initiative is becoming a rural teaching site. HGH became a teaching site for the faculty of medicine of the University of Ottawa in 2011 and for La Cité collégiale in 2012. In 2013 alone, we provided training to over 40 medical students and residents, who now have a positive exposure to medical practice in a rural setting. This will greatly facilitate future medical recruitment.

Another initiative is the Prescott-Russell health care hub. HGH is pursuing a unique model to create a regional health care hub. The concept consists of a network of facilities in Casselman, Hawkesbury and Rockland that will allow consolidation of primary and community care in line with the health links strategy of the government.

Our business model is not dependent on government capital funding. We are currently at the planning stage. However, the first of our four proposed buildings will be ready in late 2014. Our hub concept will be an enabler for the Prescott-Russell Health Link, which was the first to be approved in the Champlain region.

Let's talk about local integration in Prescott-Russell. In 2009, the Champlain LHIN, in collaboration with the four hospitals in the eastern counties, launched a major review of the distribution of clinical services across all counties. The process, which included broad community consultation, extended over a two-year period. Through this exercise, significant gaps in core program areas were identified in Prescott-Russell.

Through this planning exercise, the LHIN provided extensive population-needs data and substantive planning reports. The LHIN, in collaboration with stakeholders, came up with a set of key recommendations. However, at the end of the day, it was left to the stakeholder groups to consider any future steps. As a board, we decided that HGH should exercise leadership at the local level and drive an agenda of change in collaboration with other committed health partners.

Starting in 2011, our board earmarked some internal funds—close to \$2 million—to pursue the priorities identified together with the LHIN. Some of these include geriatrics. We joined the CCAC in actively pursuing a Home First strategy for discharged patients. With LHIN funding, we have implemented an assisted-living program where patients are discharged earlier to their home, with supportive care in the home provided by hospital staff. We've been able to maintain our ALC ratio at less than 10% during the past three years, one of the best ratios in the Champlain region.

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Another recommendation that we took action upon is mental health and addictions. Over the past three years, HGH assumed an ongoing leadership effort to repatriate programs from Ottawa hospitals, consolidate services, and build a regional community of practice. Thanks to the endorsement of the local providers and local community support, we were able to pull it through. Our foundation just completed a \$250,000 fundraising effort to support the program. Prescott-Russell went from being the poor relative in Champlain in terms of mental health and addictions, and now benefits from having a comprehensive, integrated regional program. In 2012, HGH won a national prize for its innovative undertakings in mental health and addictions.

These specific examples I've given illustrate that a new reality is emerging in Prescott-Russell. We are building a more integrated, more cost-effective system at a local level.

The LHIN's role in local/regional integration: Our experience with the LHIN has been positive because, as the major health care institution in Prescott-Russell, we accepted to assume a leadership role that went beyond the traditional mission and mandate of the hospital. The board understood two important elements in the area of integration. First, the LHIN has resources, expertise and a broad mandate. However, it has been clear from the beginning of the planning work for the eastern counties in 2009 that the LHIN would not direct or lead integration. It had to occur based on strict goodwill on the part of the providers.

Secondly, our region has a number of local health care providers such as the family health team, the CCAC local office and the health unit. However, the hospital, with administration and financial resources, was the best positioned to be the catalyst of change and integration, and this role was certainly expected of us.

The stated principle underlying the creation of the LHINs was that health care services are best managed at the local level. LHINs were seen to be a mechanism for overcoming existing health care silos and improving integration and coordination of services that would hopefully lead to a more patient-focused, results-driven, integrated system.

In Prescott-Russell, the LHIN has provided enabling support, and HGH has leveraged its position in the community and among partners to pursue and implement integration at the local level. The benefits for Prescott-Russell are: the interconnection of health services has been improved; there's now more equitable access to services compared to other sub-regions of the Champlain LHIN; creativity and innovation has occurred at the local level.

When looking back at the Champlain region's accomplishments over the past six years, and in particular at the accomplishments most directly related to the local health system in Prescott-Russell, we know that we still have a significant way to go to achieve integration. Why? Well, quite simply, we feel that more meaningful integrated planning and partnerships should be in place to provide patients, clients and communities with a truly person-centred health system versus a provider focus. I think that the slow start of the health initiative in the Champlain region illustrates the point. HGH, like other health service providers, needs to seriously question the extent to which it has truly achieved the integration, as stated in the law. Our guess is, not entirely, and it has depended on whether or not we and our partners were willing to put the needs of the region ahead of our own agenda. In this answer lies a possible reason for some of the LHIN's limitations, lack of collaborative leadership between providers, and lack of a clear leadership role by the LHIN. This reality continues to inhibit progress, although opportunities exist now to achieve a higher level of integration.

Now some key considerations: Given the importance attributed to the province-wide health links strategy, the

health link is now the major project under way for health care integration in Prescott-Russell.

The 12 partners of the Prescott-Russell Health Link, including the hospital, have developed draft values and guiding principles. Why? Very simply, because they have come to realize that it is their engagement to the health link and to each other that will bring success. These values are collective trust and respect, collaboration, and being truly client-centred. Our decisions and actions must, first and foremost, consider the needs and interests of the client before our own.

In closing, my colleagues and I on the board of the HGH believe that the time has come for the Ministry of Health and Long-Term Care, the LHINs and the health care service providers to take a step back and evaluate the extent to which we are individually and collectively aligned with the directions and objectives that were set through the act.

We should accept that a new version of the law must inevitably strengthen the accountability of the LHINs and the service providers, creating the right conditions for a more integrated, cost-effective and client-centred system at the regional/local level. In other words, we need to put the patient and the region first. Integration is about filling the gaps and connecting the dots.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We'll have questions from the third party. Ms. Gélinas?

M^{me} France Gélinas: Une petite question facile avant de commencer. Tu as dit que les patients en attente des « ALC », en attente de placements—ce sont les employés de l'hôpital qui les suivent à la maison?

M. Sébastien Racine: Je ne peux pas aller dans les détails moi-même mais il y a eu beaucoup de travail de fait en partenariat avec le « CCAC ». Il y avait de ce travail-là qui était fait par l'hôpital avant et maintenant c'est fait conjointement. Je ne pourrais pas vous dire techniquement le rôle de chaque personne.

M^{me} France Gélinas: Est-ce que—

M. Sébastien Racine: M^{me} Heuvelmans, la vice-présidente de l'hôpital, pourrait répondre à cette question, si vous voulez.

M^{me} France Gélinas: Je vais aller la voir après.

M. Sébastien Racine: OK.

M^{me} France Gélinas: Est-ce que, donc, dans votre région, l'hôpital offre également des soins primaires?

M. Sébastien Racine: On est un modèle d'hôpital basé sur les « general practitioners ». Donc, ça tient les médecins de famille et les « family health teams ». On a un très bon « family health team » dans la région, très près de l'opération. On a de très belles collaborations. Le projet de « health links » renforce ces liens-là, puis notre projet de travailler sur un « hub » renforce aussi cette proximité avec les médecins. Donc, il y a une très grande collaboration parce qu'on travaille de très près.

M^{me} France Gélinas: Tu as entendu ce qui a été présenté ce matin; j'ai vu que tu étais là. Puis, l'idée d'avoir un conseil d'administration ou un conseil

régional qui serait le conseil d'administration pour l'hôpital, pour l'équipe de santé familiale et pour tous les joueurs dans une région, comme il a été mentionné, est-ce que c'est quelque chose qui vous intéresse?

M. Sébastien Racine: Je ne sais pas si ça c'est la formule, mais je pense, comme le D^r Keon l'a mentionné, que les conseils d'administration ont un rôle à jouer. Nous, on a fait notre planification stratégique et elle est en lignée sur celle du RLISS et sur celle du plan d'action. Ensuite, il devrait y avoir plus de discussions inter-conseils d'administration et entre les différents organismes. Un peu comme le D^r Keon l'a mentionné, ce n'est pas qui détient le pouvoir, mais de s'assurer qu'on travaille vraiment ensemble.

Si c'est une formule qui—je ne peux pas me prononcer à ce moment-ci.

M^{me} France Gélinas: Non, ça va, ça va. Donc, ce que tu nous racontes, ce qui s'est passé ici, dépendait beaucoup de la bonne volonté de votre conseil d'administration. Si votre conseil d'administration avait dit non, rien de ça ne se serait passé?

M. Sébastien Racine: La bonne volonté du conseil d'administration, puis, comme de raison, tout au niveau des administrations—quand les administrations sont appuyées par leur conseil d'administration et qu'il y a beaucoup de discussions avec les autres « providers », ça va créer des opportunités.

Au contraire, oui, ça pourrait arriver que si les gens ne collaborent pas à tous les niveaux administratifs ou au niveau de la gouvernance, il peut y avoir des blocages.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time, and we thank you very much for your presentation.

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RÉSEAU DES SERVICES DE SANTÉ EN FRANÇAIS DE L'EST DE L'ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is from the francophone services of eastern Ontario: Lucien Bradet, president, and Jacinthe Desaulniers.

Interjections.

The Chair (Mr. Ernie Hardeman): You can introduce yourself to the Hansard as we're proceeding, and that will save me embarrassing myself even more.

Thank you very much for being here this morning. As with the other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time as you see fit. If there's time left at the end, we will have some questions or comments from the committee. With that, your 15 minutes starts right now.

M. Lucien Bradet: Merci beaucoup. I will speak in French. I think that you have the facilities.

Mon nom est Lucien Bradet. Je suis le président du Réseau des services de santé en français de l'Est de l'Ontario. Je suis en compagnie de Jacinthe Desaulniers, qui est notre directrice générale.

D'entrée de jeu, nos constats sont positifs. Nous adresserons au comité une recommandation de modification du règlement dans le but de consolider les avancées du système de santé pour ce qui est des services de santé en français.

Le réseau a été nommé entité de planification des services de santé en français par la ministre de la Santé et des Soins de longue durée en 2010, conformément au règlement 515/09 sur l'engagement de la collectivité francophone. Nos principaux partenaires sont les RLISS de Champlain et du Sud-Est, avec qui nous avons signé une entente de responsabilisation.

Le réseau compte près de 400 membres individuels, soit des résidents de l'Est ontarien qui ont à cœur la santé en français. Nous avons aussi 67 membres corporatifs—on a parlé tout à l'heure de 200 à travers la région, mais 60 membres de ces 200-là sont corporatifs—c'est-à-dire, des organismes qui offrent des services de santé en français dans les régions de Champlain et du Sud-Est. La population francophone de Champlain et du Sud-Est s'élève à près de 258 000 personnes, ce qui représente 42,2 % de la population francophone de l'Ontario.

Mesdames et messieurs, il y a exactement sept ans, notre réseau comparaisait devant le comité de la politique sociale qui se penchait sur le projet de loi 36 sur l'intégration du système de santé local. Alors et encore aujourd'hui, nous sommes favorables aux fondements d'un système intégré basé sur les principes d'imputabilité, de qualité et de soins centrés sur le patient.

Depuis, la loi de 2006 tient compte des francophones de différentes façons :

- la référence à la Loi sur les services en français en préambule;
- un conseil consultatif pour conseiller la ministre ou le ministre;
- l'engagement de l'entité de planification par le RLISS; et finalement
- un règlement sur l'engagement de la collectivité francophone.

Ce règlement a été bien accueilli par notre communauté. Par l'entremise de l'entité, la communauté a une voix au chapitre de la planification du système de santé local. Ces avancées sont significatives pour la communauté francophone dans le domaine de la santé. Localement, les trois dernières années ont été marquées par la collaboration entre le réseau et les RLISS. Je vais demander à la directrice générale de nous en dire quelques mots, et avec des exemples précis.

M^{me} Jacinthe Desautniers: Bonjour. Je vais identifier deux exemples d'actions conjointes qui ont une portée structurante sur le système de santé local. La première, c'est les solutions qui ont été développées pour répondre à l'absence de données probantes sur la santé des francophones. Le deuxième exemple, c'est la systématisation du processus de désignation, dont l'appui aux fournisseurs de services de santé, l'analyse régionale de la capacité d'offre de services de santé en français et

les recommandations de désignation qui ont été faites auprès du ministère. Ce sont là des exemples directement reliés à la planification, la responsabilisation et l'amélioration de l'offre de services de santé en français dans la région.

Le réseau a aussi émis aux RLISS une série de recommandations sur des initiatives et processus reliés au système de santé afin d'assurer l'inclusion de la perspective francophone dans la planification du système. L'an passé, 91 % de ces recommandations ont fait l'objet d'une action par les RLISS en partie ou complètement conforme à nos recommandations. Nous sommes fiers de ce résultat qui illustre la pertinence de nos analyses, le degré d'interaction entre nos instances régionales, et l'ouverture des RLISS à ce partenariat. Nous sommes aussi sûrs qu'à terme, les mesures recommandées et mises en place auront une incidence sur l'offre et qualité des services offerts aux francophones.

Maintenant, à l'échelle de la province, l'expérience des trois dernières années a permis d'identifier un enjeu fondamental dans l'application de la loi et du règlement : celui de l'absence d'un cadre d'imputabilité clair, transparent et complet pour les services de santé en français en Ontario. À l'heure actuelle, la loi et le règlement favorisent des actions et des mesures régionales d'engagement et de planification des services offerts aux francophones.

Nous vous soumettons que le système de santé peut faire mieux. Nous avons besoin d'une véritable cascade d'imputabilité, c'est-à-dire un enchaînement logique des responsabilités et obligations reliées aux services de santé en français en province.

En effet, nous faisons le constat qu'il y a absence de clarté, de transparence et de rigueur dans la responsabilisation sur les services de santé en français. Donc, il y a absence entre le ministère et les RLISS, entre le ministère et les entités, entre les RLISS et les entités, et entre les RLISS et les fournisseurs de soins.

Je vais vous donner quelques exemples. Il n'y a pas de référence aux obligations à l'égard des services de santé en français dans l'entente entre le ministère et les RLISS. Il n'y a pas de lien de responsabilisation entre le ministère et les entités. La forme actuelle de l'entente entre les RLISS et les entités fait qu'il est parfois difficile pour une entité d'assumer pleinement son rôle-conseil dans la dynamique de redevabilité au RLISS. La présence et la teneur de conditions locales à l'intention des fournisseurs de services de santé par rapport aux services en français varient considérablement d'une région à l'autre. Finalement, comme dernier exemple, on ne retrouve aucune mesure des services en français dans les indicateurs de performance pour le système.

À vous, monsieur le président.

M. Lucien Bradet: Nous sommes d'avis que l'atteinte de résultats tangibles quant à l'offre active de services de santé en français dépend d'une articulation de chacune des dimensions du système de santé : systémique, organisationnelle, professionnelle et individuelle.

Nous témoignons aujourd'hui pour signaler l'impact positif qu'ont eu la loi et le règlement sur les services pour les francophones et pour encourager la province à continuer d'exercer son leadership à l'égard des services de santé en français.

Nous pensons qu'il est possible de poursuivre dans la voie d'une meilleure efficacité du système local à l'égard des services de santé en français par un changement soit du règlement ou de la loi. Par conséquent, nous recommandons que la province de l'Ontario bonifie le règlement ou la loi en y ajoutant un cadre de responsabilisation pour les services en français : complet, à tous les niveaux et explicite sur les rôles et responsabilités de chacune des parties.

Dans ce cadre, nos recommandations :

(1) L'intégration de la perspective francophone dès le début et tout au long du développement de politiques et programmes provinciaux;

(2) Le développement et l'instauration d'indicateurs de performance à l'égard des services en français pour les RLISS, pour les entités et pour les fournisseurs de services; et

(3) L'établissement d'un mécanisme de concertation sur les enjeux liés à la santé des francophones et aux services de santé en français, qui implique le ministère, les entités et les RLISS.

Nous vous remercions, et nous sommes ouverts à toutes questions. We are open to any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We do have six minutes left, so we'll have two minutes from each party. We start with the official opposition: Ms. Elliott.

Mrs. Christine Elliott: Merci. Thank you very much for coming today and for presenting your perspective. I understand that there seem to be great discrepancies in various parts of the province with respect to the provision of French-language services. So the framework that you're suggesting will ensure that there's equal access across the province. Is that—okay.

How do you think we could go about doing that? Is it greater representation on the LHIN board itself? What would be the best way to directly ensure that the francophone communities across the province are being served?

Mr. Lucien Bradet: My personal view, and Jacinthe can add to that, is that the leadership must come from the province first. We've said, as francophones over the last 100 years, that the province is the authority that can give real leadership when it comes to French-language services in terms of legal framework and rules, and so forth. I think that the province should dictate or should be clearer with the RLISS on the representation. In Ottawa, we have two out of nine, and we are pleased with that. It's not in the law. It's the goodwill of the chair and the province. Goodwill is good, but it's not enough to firm up our rights and the roles that we have.

1030

Ms. Jacinthe Desautniers: Thank you for the question. It gives us an opportunity to expand on what we mean by a "cascade of accountability." Really, what it

means is looking at the roles, the obligation, and then the performance indicators of everybody involved in the system. We start at the provincial level with the ministry, then we look regionally at the LHINs and the entities, and we go all the way down to the suppliers of services who are first on the ground. So really making sure that we understand the responsibilities, the obligation and the performance indicators so that that cascade of accountability can occur.

The Chair (Mr. Ernie Hardeman): Thank you very much. Next is Ms. Gélinas.

M^{me} France Gélinas: Merci beaucoup pour votre présentation. J'ai trouvé très intéressant la façon dont vous mettez de l'avant une nouvelle relation qui ne serait plus basée sur une relation hiérarchique où le RLISS vous finance et vous dirige au travers du cadre d'imputabilité. Mais là, ce que vous proposez c'est vraiment une hiérarchie plate où vous collaboreriez avec le RLISS pour son mandat de services en français. Est-ce que j'ai bien compris?

M. Lucien Bradet: Je pense que oui. Je pense que la question de services en français pour nous—on pense qu'on a une responsabilité première et on pense que, lorsque le gouvernement a établi les entités, c'est ça qu'il avait en tête. Le RLISS avait besoin de conseils; on en donne. On devrait être considéré comme des partenaires. La question monétaire, par exemple, qui est passée via les RLISS : le gouvernement avait dit, « Bon, on va vous financer. Les entités vont être financées. »

Il y a parfois des moments où on pense qu'on est juste une autre agence, mais on n'est pas juste une autre agence. On est, à mon avis, légalement responsable d'aller plus loin pour les services en français.

Je ne sais pas si ça—

M^{me} Jacinthe Desautniers: Peut-être juste une note historique : dans Champlain, la collaboration, comme on l'a décrite, va très bien. Je pense que c'est parce que notre collaboration pré-date cette entente-là avec les RLISS. On avait une entente de collaboration, donc cette histoire-là de travailler ensemble en partenariat pour l'amélioration de l'offre de services de santé en français, ça a déjà été fait dans le passé.

M^{me} France Gélinas: Donc—

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Fraser?

Mr. John Fraser: Merci pour votre présentation. Je parle français un peu et je pose ma question en anglais in the interest of time. What do you mean by "cascade of responsibility"?

Mr. Lucien Bradet: Cascade: We have the government, the LHINs, les entités, le réseau et les « providers ». On pense que chacun de ces niveaux-là, each of those levels has a responsibility towards more French services, because that was the intent of the Parliament or of the Legislature. So we would like to know who is responsible for what, how it's going to be judged and what the indicators of performance are. At this point in time, there's only a statement of principle

that we should give more. It leaves us too much in a quandary of who is responsible for what, and so forth.

We had a meeting on the 17th of January in Toronto. We asked the department about the role and responsibility; it was the first item on the agenda. They didn't say a word about it—not a word. We were very surprised. We asked the question. We said, "What about the role and responsibility?" "Well, next question." We are concerned by that.

Mr. John Fraser: Merci.

The Chair (Mr. Ernie Hardeman): Anything further? If not—

Mr. John Fraser: Do I have time?

The Chair (Mr. Ernie Hardeman): Yes, you have a little bit more time.

Mr. John Fraser: Why do you think it's important to have a provincial consultation?

Ms. Jacinthe Desaulniers: Because over the last three years, we have realized that the issues are common. Many of the francophone issues are common across the 14 LHINs so it does make sense that we don't duplicate efforts and that we work collaboratively because it's the right thing to do. We've done it. The entities have regrouped, and we've tried to collaborate. Chantale LeClerc, who was here today, is actually the representative for the LHINs for francophones, with Madame Paquette, but there's no formal structure in place. We've done it, although there is an obstacle for us doing it. So we're just saying, let's formalize it. We really need to do this. There are some unique needs, but there are some that are common.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's very much appreciated.

Our next presenter is Arnprior Regional Health: Eric Hanna. I believe they may not be here yet. We are slightly ahead of time, because we did have two cancellations, so I think we will just break for a health break.

The committee recessed from 1035 to 1044.

ARNPRIOR REGIONAL HEALTH

The Chair (Mr. Ernie Hardeman): This is the same challenge I have at every event I go to—when it's the start of the event and they ask the dignitaries to speak, they always say, "Ladies and gentlemen, if I could have your attention. We just have a few things we want to clear up, and then you can go back to enjoying yourselves." We do have a few things to clear up, and our next delegation is here, so I think we'll start doing that, and then as the day wears on, we can get back to enjoying ourselves.

Our next presenter is Arnprior Regional Health: Eric Hanna, president and chief executive officer. Welcome to our committee. You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left over, we'll have some questions from the committee. With that, the next 15 minutes are yours.

Mr. Eric Hanna: Thank you very much for the opportunity to give you a presentation. I've given an awful lot of thought to what I can include in this presentation.

This reminds me of the first time I was doing some hospital restructuring back in Kincardine about 15 years ago and I came to an arena like this, and we were recommending looking at some amalgamation of hospitals. We were supposed to meet in a room like this, but by the time we got ready to go, we moved down into the arena, and we had 7,000 people in the arena—not quite what I was expecting, and similar for this one, I must admit. But I'm very pleased to be here.

I've been in health care now for close to 30 years. I've worked for hospitals. I've worked for a national consulting firm. I worked for one year in the Ministry of Health. So when I put this together, I reflected upon an awful lot of my experiences, and based upon that, I tried to suggest what I thought was working well and areas where I thought there were some opportunities for improvement.

For those of you who are wondering where I may be coming from, from a particular bias, I'm from Arnprior, which is located about 45 minutes on the other side of Ottawa, so about two and a half hours away from here. I'm bringing in the perspective of an already integrated organization. I think that's one of the key opportunities that the LHIN has: to continue to foster integration. You can see our organization has a hospital, a long-term-care facility, an adult day program, assisted living services. So when you see some of the observations that I have, you can see that that's because of that perspective that I'm bringing to you.

We also serve a mix of urban and rural geography. Our catchment area is about 30,000 people, so it's not all that large, but it's large enough to give us the diversity of having about 30% of our population over the age of 75, and we have about 30% of our population of seniors living alone as well.

The outline of my presentation will include SWOT—the strengths, weaknesses, opportunities of the LHIN—some recommendations and then your questions.

From a point of view of the strengths, one of the things that I was most pleased to see with the LHIN is their ability to take the policy direction of the Ministry of Health and then translate it down to the local area, and the most significant example of that is the reduction in alternate-level-of-care patients in the Champlain LHIN. We have made significant strides in this, taking a provincial objective and then driving it down to the local area.

1050

Working with the LHIN staff, we've come up with an awful lot of innovative ideas that are unique to our communities, and I think that's one of the benefits that we get. This is not about taking a made-in-Toronto solution and then trying to make it fit in our area.

I know you have a presentation going on later about support for integration, and you're going to have a presentation later on from somebody from the Eastern Ontario Regional Laboratory Association. For those of you

who aren't familiar, EORLA, the Eastern Ontario Regional Laboratory Association, took about nine years to formulate, but it was a voluntary integration. Now, in eastern Ontario, we have 16 hospitals with one lab company, if you will, but it was a voluntary integration and supported by the LHIN.

The LHIN staff are very passionate as well. I know you see this in an awful lot of strengths of organizations, but I would say this even if I did not know that the CEO and the chair were here from the LHIN.

We have the LHIN CEO and the board chair come up to our board meetings on numerous occasions and talk about what the system transformation is like. They're very passionate about what it is, and they encourage us, as organizations, to continue to move forward. The LHIN is very, very strong and very, very advocating, I guess I would call it, in terms of the health system transformation.

Where we see some of the weaknesses, then—and I think this one comes down to just trying to find this balance. In our organization, what I suggest is that we use the phrase “change used to be episodic”; i.e., every couple of months, there would be a change, and then you'd wait, and a little bit later there would be another change and another change. Now I use the phrase “change is constant now.” We're always changing.

One of the things that I think the LHIN needs to do, then, is be able to be in that mindset of saying, “You know what? You may not have everything completely studied, but you're going to have to move ahead and do it anyway.”

In my case—and I've had this discussion with the LHIN here before—our LHIN didn't have an earlier adopter for health links. We studied it and we studied it. I think we could have been quicker. We need to be more adaptive. When things start coming down, we need to start to be able to do those things in a quicker fashion. It means, then, you need to have a culture of risk taking and, I think, for the LHIN, will there be a balance in terms of how much risk they can take, not having studied everything?

There is another opportunity in terms of the LHINs lacking the consistency in the way they implement things. Policy comes down from the Ministry of Health for small hospitals, for example, and says, “You've got \$20 million to start to work on the transformation of small hospitals.” It's great that we come up with local solutions, but I think that we can develop processes for everybody to implement things in a similar manner. There was not the same consistency from one LHIN to another LHIN. I think it utilized an awful lot of resources of the LHIN that didn't need to be used.

We want to develop local solutions, but we can have common processes across all the LHINs. I've given a couple of other examples that are up there as well, where I think that might be the case.

Opportunities: As the saying goes, “Noses in, fingers out.” This is one, then, just to say, where is that balance

again of having oversight and managing accountability agreements and managing some of the detailed operations versus supporting full system transformation?

What I would like to suggest on the first two that are up there, about saying that the LHIN, in my mind, again, because of the rapid change that's going on right now—less time focusing on individual performance of the individual institutions and more on the system performance. We have an awful lot of that happening at the CEO group right now, but I think there could be more of that focusing on overall system performance and driving those types of dialogue as opposed to individual ones.

Community engagement is another one where I think there's an opportunity to improve as well—and I don't want to suggest here that I'm being perfect. In our organization, community engagement is always a struggle. As I mentioned before, using that example in Kincardine where we had 7,000 people out because we said we were going to take down the blue H signs, people will come out for community engagement then. If you just say we're going to talk about what the future could look like, and nothing substantial is going to change, it's tough to get people out. I don't have the right answer for it, but I would like to suggest respectfully to the LHIN that we've got to find a better way of getting more people engaged in what is happening.

I think the last bit, under “Other opportunities,” is matching the skills to the tasks at hand. Some of the people who are in the LHIN offices right now do not necessarily have experiences in the health services provider area. I was fortunate; I was seconded into the Ministry of Health for a year and worked on an awful lot of projects. I brought the hospital experience into the Ministry of Health. There are an awful lot of very well-intentioned individuals in the LHIN right now, but they don't have that practicality of working in a health service provider to be able to bring and oversee certain practical solutions. What happens then is that sometimes the LHIN loses credibility with the health service providers when you're trying to engage them, and I know our LHIN is aware of that.

Threats: We have an integrated health services organization right now, as I suggested before. The LHIN would love to say, “Eric, we could move money from the hospital over into long-term care or move money from the hospital into community-based services.” You can't do that now. I go to some national conferences and talk to my colleagues out in British Columbia, and they say, “We're making a better health care system.” It meant the vice-president of patient care on the hospital side talked to the vice-president of community-based services, they shook hands and said, “We're going to move a half a million dollars from here over to here,” and it was done. So we may have the best intentions as a LHIN and as health service providers, that we want to integrate and actually move money from one organization to another one, but we can't do that in the way that things are organized now because of the siloed funding. The same

type of thing happens down on another one that I'll talk about later, under health service arrangements. I haven't seen this one as much, in terms of not having the primary care physicians under the LHIN or having the emergency health services. I've heard it from other colleagues, saying, "We're trying to develop better solutions, but we need to make sure that emergency services are at the table, and the LHIN needs to be able to direct that."

The other part that's on the last of the threats is one that talks about the appointment of new board members. Again, I'm speaking as a CEO in our organization. I know what it's like in our organization if I'm missing two or three board members for a long period of time. I'm missing that skill mix. I'm missing that geographic representation. I think the same thing happens here in our Champlain LHIN. I know there have been times when there hasn't been a board member on there for many months, and, as a result, where I am in Renfrew county, there may not be any representation or that skill set. I'm not here suggesting that the order in council is wrong; it just needs to get done in a much more expeditious fashion.

Recommendations: As I said before, we need to constantly evaluate how we're delivering the LHIN services, especially now, recognizing that change is much more rapid. When I look at recommendations, then, I'm going to give you a couple under the areas of structure, culture and skills.

Under structures, I talk about the first one: Looking at a different type of process to expedite the appointment of board members to the LHIN, to ensure that they always have a full complement of governance leadership. Support the LHIN administrative processes by streamlining for an integrated health services agreement, i.e., one accountability agreement. As I said before, I have a nursing home, we have assisted living services and we have a hospital. I have three accountability agreements, and my board is pulling out their hair and asking, "Why do we need to have three of these types of things?" Not only is it my time that's required for this, it's also the LHIN's time. So if you're going to really ask for an integrated health delivery system, create the structures that are going to allow that to happen, one being a multi-service accountability agreement that will allow us to have just one with all the different parameters.

Find mechanisms to consistently roll out Ministry of Health policy across the LHINs. If you have a strategy that the ministry wants to have, roll it out. One of the things that I found that's a little bit different—when we used to have the area teams in the Ministry of Health, they would be decentralized out here. I found there was more consistency in the way that the policy was being implemented in the various geographic areas than there is right now. What has happened now is there's a strategy being developed in Toronto, if you will, that's asked to be implemented by all the LHINs, but there's too much variation. I sit on a couple of provincial committees where I'm actually starting to see this now. I'm chairing a committee for small hospitals, and I'm hearing what

one LHIN is doing versus another LHIN versus another one in trying to achieve the same objective. We're trying to organize our efforts to be effective, and saying, "Well, in this LHIN you're going to have to do it this way because they have a different process; in this LHIN they're doing it this way; in this one they're doing it that way." Everybody is trying to achieve the same goal, which is great, but I still think you can have local solutions with a common process.

Skills: I would talk about the skills of the LHIN staff to have community engagement. I think that's very important. There are some people who are learning those skills. In our own organization, we're trying to build that skill set as well.

Additional expertise in health service providers or the LHIN staff: Whether or not it's a secondment into a health service provider or whether it's just trying to hire people out of hospitals or community-based services etc., we can look at that.

As well, we need to make sure that the staff complement is moving away from people who are detail-oriented, looking at micro initiatives at individual sites, into a larger system transformation. Again, it's a different skill set, as the role of the LHINs have changed and the tasks have changed.

1100

The last one I think that's there is similar to what I've been stressing all along. I have it up here as being rebalanced. I'm not too sure if it's a rebalance or just greater emphasis. Again, I myself, as a health service provider, want to view the LHIN as being a strategic partner, helping me to transform the health care system—and not thinking that when I get the call from the LHIN, it's going to be, "Well, line 6.2 on your accountability agreement is off by 10%." I don't want to feel that that's the way it is. I can tell you that with the CEO and the chair, that's not the way it is. But some of the staff—I think they honestly believe that's what they're there for: to monitor the performance as opposed to leading the change. And there are many of us in the field who want to do that. That's just that culture of the organization. That's one part of your function, to monitor performance, but your other part is to support transformation.

The Chair (Mr. Ernie Hardeman): Thank you very much for a very-well-thought-out and worked-out presentation. You have, at that moment, finished 15 minutes, so thank you.

Mr. Eric Hanna: My technical glitches.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It is much appreciated, and it will be greatly helpful to our committee as we pursue our report.

CHAMPLAIN COMMUNITY HEALTH
CENTRE EXECUTIVE DIRECTORS'
NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Champlain Community Health

Centre Executive Directors' Network: Jack McCarthy, executive director of Somerset West Community Health Centre, and Simone Thibault, executive director of Centretown Community Health Centre.

So everybody can give full attention to the presentation, we'll just wait a minute.

We want to thank you for coming in this morning to speak to us. You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left over at the end, we'll have some questions and comments from the committee. With that, your 15 minutes starts right now.

Mr. Jack McCarthy: Thank you, Mr. Chair. Good morning, ladies and gentlemen. It's a pleasure to be here. It's a pleasure to be with a former colleague, France Gélinas. As fellow executive directors, we worked on some of the issues of advancing primary health care in this province. It's nice to see France again, in a different capacity, here at the committee.

My name is Jack McCarthy, and I am the executive director of the Somerset West Community Health Centre in downtown Ottawa. I'm joined by my colleague Simone Thibault, who is the executive director of the Centretown Community Health Centre. We work very closely on many issues, as we do with many of our other partners. We're here today speaking on behalf of the Champlain Community Health Centre Network, of course, to you folks, as part of your review of the Local Health System Integration Act.

In case you may not know, community health centres are a community-based model of care that provide comprehensive primary health care services, in combination with health promotion and illness-prevention services to people who typically have barriers to accessing health care.

A quick primer: There are currently 75 CHCs in Ontario, 11 of which are located in the Champlain LHIN. They are: Carlington CHC, Centretown CHC, Pinecrest-Queensway CHC, Sandy Hill CHC, Somerset West CHC, South-East Ottawa CHC, in Ottawa; in Cornwall, Centre de santé communautaire de l'Estrie as well as Seaway Valley Community Health Centre; Lanark Health and Community Services in Lanark; and in Killaloe, the Rainbow Valley CHC. In addition, our CHCs in the Champlain LHIN also operate a number of satellite sites to expand access to those in need of primary care services.

Our goal today is to highlight the strength of the Champlain LHIN, as experienced by CHCs, while also making some concrete recommendations on which ways we think the LHIN can function better.

We have four main points to address: the role of the LHINs in supporting local collaborations between stakeholders, the scope of the LHINs with respect to primary health care, and the authority and decision-making of LHINs; finally, the fourth point we'll go into is the relationship between better data management and accountability.

First, local collaborations have increased. First of all, we believe that our LHIN has been largely successful in accomplishing a key aspect of its mandate: that of co-ordinating health care within the local system. We're fans; it's working well.

The fact that the Champlain LHIN's board and staff are located close to the communities they serve allows for a better understanding of the specific realities that are faced by the communities that we're here to serve. This has meant that our LHIN has enthusiastically supported discussions between local stakeholders that have led to greater collaboration within the health sector. For example, the Champlain LHIN has ensured that important networks, reflective of the diversity of our populations, have been strong partners involved in identifying specific needs within the local health sector and improving the system. These networks include the aboriginal health access centres, or AHACs; the French Language Health Services Network of Eastern Ontario; and the Ottawa Local Immigration Partnership. Reflecting the needs of these networks in our discussions and decisions has been key.

In this regard, our LHIN has demonstrated strong leadership in promoting dialogue between health service providers in the home care sector, the acute care sector, and in primary health care. For example, in the past year, senior staff at CHCs and the CCAC have met to explore ways to identify how to serve mutual clients with complex care on a neighbourhood basis. Another example is our primary care outreach program, led by South-East Ottawa CHC and integrated within each Ottawa CHC. This program, made up of a tag team of a nurse and a community health worker, targets the frail elderly and has developed a strong partnership with area hospitals, city emergency services, the CCAC, home support programs and others to support improved navigation of a particularly vulnerable population. CHCs have also been active participants in the development of health links.

M^{me} Simone Thibault: Alors, Jack vous mentionne que oui, on a des éloges pour le RLISS de Champlain, mais on va vous parler du mandat des RLISS et comment on verrait que ça pourrait être élargi.

Alors vraiment, on croit fermement que le mandat en matière de soins de santé primaires pour le RLISS devrait être élargi. Bien que le RLISS aide déjà à faciliter le dialogue en santé, comme Jack l'a mentionné, nous croyons qu'il faudrait élargir son mandat en soins de santé primaires.

Nous aimerions voir le gouvernement de l'Ontario travailler à la création d'un système de santé primaire plus robuste qui se préoccupe des déterminants sociaux de la santé, ainsi que des services de promotion de la santé, de prévention, et de santé mentale et de toxicomanie. Selon nous, le meilleur moyen pour ce faire est d'étendre et d'élargir le mandat du RLISS en matière de soins de santé primaires.

Les centres de santé communautaire sont les seuls fournisseurs de soins de santé communautaires qui

relèvent du RLISS. Le mandat du RLISS exclut donc les équipes de santé familiale et d'autres modèles. Il est essentiel de créer un environnement où tous les organismes de soins de santé primaires relèvent de la même autorité et rendent des comptes au même organisme de la région. Par conséquent, le fait d'élargir le mandat du RLISS renforcerait le système de santé en améliorant le dialogue et la planification des services de santé à l'échelle locale. Pour qu'il soit possible de coordonner les soins dans le cadre de maillons santé, tous les modèles de prestation de soins primaires devraient relever du RLISS, qui serait alors capable de faciliter l'intégration des différents organismes de soins de santé primaires.

While the role of the LHINs as managers of health services is necessary, it is not sufficient in itself to ensure solid and sustainable local health systems. Expanding the legislative scope of the LHINs to include all primary health care models under the purview of the same local planning structure that CHCs are under will create a more robust and responsive health system. The emphasis of the LHINs must shift to focus on keeping people well, not just treating them when they get sick. This means ensuring effective primary care, which we all know is the foundation to our health care system.

Our third point: We strongly believe that the LHIN has to expand its primary health care mandate.

Nous souhaitons que le RLISS ait une plus grande autorité. Bien que nous soyons d'accord avec le fait de conserver des structures régionales dans le cas des autorités sanitaires et de la planification locale, nous pensons que ces structures devraient avoir davantage de pouvoir sur les décisions de financement. À l'heure actuelle, la capacité des RLISS à accorder et à réallouer des fonds est restreinte, ce qui retarde les efforts d'intégration locale.

Nous avons observé plusieurs cas, mais on a deux cas qu'on aimerait mentionner avec vous où le fait d'accorder une plus grande liberté au RLISS pour l'attribution du financement aurait des effets positifs sur la communauté. Le RLISS doit avoir un meilleur contrôle sur la réallocation des surplus du financement aux médecins et davantage de pouvoir sur le financement des projets d'immobilisations. Pour nous, il n'est pas très logique que ces décisions soient prises à Queen's Park.

Par exemple, les centres de santé communautaire dans la région de Champlain, on collabore ensemble et on a élaboré ensemble une proposition de programme de services de physiothérapie à l'échelle du RLISS en réponse à un appel de propositions. Nous avons soumis notre proposition en juillet 2013, puis les représentants du RLISS nous ont bien avisés que leur examen était terminé quelques semaines plus tard et que la décision serait prise par le ministère de la Santé et des Soins de longue durée. Huit mois plus tard, nous n'avons toujours reçu aucune nouvelle. Notre exercice financier se termine dans sept semaines. Pourquoi cette décision ne peut-elle pas être prise localement par le RLISS?

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Giving the LHINs greater authority over key funding areas would remove a number of significant barriers that we have noticed to the integration and implementation of community-based services.

Mr. Jack McCarthy: Our fourth and final point: data management and accountability. There is a real need for more integrative data-sharing practices among health service providers at all levels of the health system, and the LHIN has a key role to play in enabling this exchange. What we care most about is accessing and sharing useful local data that is comparable and relevant across sectors.

Data-sharing needs to be transparent, so that all members of the health system have access to the information they need. We simply cannot be held accountable for data that we don't generate or don't have access to. What we need is a better way of tracking relevant data to improve the flow of people through the health system. In that respect, improved data-sharing goes hand in hand with reporting meaningful accountability measures.

In our experience, data-sharing among CHCs in Ottawa has led to great improvements in the ability of providers to collaborate and work together to improve outcomes. Simply put, if you show people relevant and useful data, they will work to improve the gaps in the system.

As we move to expand health links in Ontario, we need to ensure that all members who are held accountable for improving care coordination have the ability to access relevant, transparent and comparable shared local data. This will put HSPs, or health service providers, in a better position to reasonably measure their progress towards meeting accountability indicators set by the LHIN and the ministry.

We believe that LHINs are in a unique position to act as an enabler of good data-sharing practices among sectors within local communities. LHINs would benefit from taking a greater leadership role with respect to enabling wider data-sharing among health service providers. Without more integrative data management, it will continue to be difficult to adequately measure progress.

In conclusion, the Champlain LHIN is to be commended for facilitating local planning and developing the Integrated Health Service Plan. A local plan that we can all have input into makes sense. As a consequence, this planning has brought different health system providers together in a common dialogue on the needs of clients and patients in the Champlain LHIN.

Secondly, expanding the mandate of the LHINs to include family health teams and possibly other primary care providers will only serve to strengthen the focus on keeping people well.

Thirdly, bringing decision-making closer to communities that are affected by those decisions is very much the right thing to do. For our sector, being able to meet with LHIN staff on a regular monthly basis is far superior to dealing with Ministry of Health staff based in Toronto. We have developed effective and productive working relationships.

The Ministry of Health has to devolve more authority to the LHIN. If our emerging economic realities require our health care system to do more, better, for less, then the question becomes, who is best positioned to decide on the allocation of health care resources locally? A strengthened, better-resourced and community-led LHIN is better than dealing with the Ministry of Health in each of its fragmented ministry silos.

Lastly, we strongly believe that the LHIN has to play a key role in promoting data-sharing agreements among health service providers, so that we all have comparable data to work with and accountability measures that fit appropriately for each group of health service providers. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about two and a half minutes left. The third party: Ms. Gélinas.

M^{me} France Gélinas: I know that you did not talk about this directly, but I will bring it up, because we hear it everywhere we go: this idea that primary care should coordinate care for the people needing home care. In other words, some of the coordinating functions that are being done by CCACs right now could be better done by primary care providers. Although we're reviewing the LHINs, it comes up often. You haven't touched on it. Are you comfortable sharing your thoughts?

Ms. Simone Thibault: We value the relationship of working hand in hand with the CCAC, but I think there is also a role for primary health care in terms of coordination of that, because we do it, and we do it with very limited funds. I think it's worth looking at to see how best we could build on what's centralized versus decentralized and working more closely with the primary health care sector to make that happen. It's often about relationships on the ground, and really, home support services have to be highly linked with primary care to make it work.

Mr. Jack McCarthy: Just to add to that, I think there's a role for both to work really effectively well. So for us—and we've started this dialogue with the CCAC—in a particular catchment area of our community health centre, say it's Somerset West, let's identify mutual clients so that we're wrapping services around them effectively. We've got work to do on that. I think there's a lot of informal collaboration and formal collaboration that is good, but I think there's a viable role for both.

M^{me} France Gélinas: When you say "bring primary care under the LHINs," you focus on family health teams. Do you purposely exclude fee-for-services physicians?

Mr. Jack McCarthy: No. Practically speaking, I think it would be easier to start off with family health teams, who we are starting, as CHCs to collaborate more with, in terms of the evolution of these health links. But, absolutely, my own belief here is that family physicians and primary care providers within a geographical area should all be under the purview.

How do we plan for H1N1, God forbid there's a pandemic? We have to work closely with all family physicians and primary care providers locally to mount an effective population health response to a crisis as a starting-off point.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation this morning. We very much appreciate it.

CHAMPLAIN COMMUNITY SUPPORT NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation—I understand Alex McDonald is not here at the present time, but the next one, the Champlain Community Support Network: Valerie Bishop de Young, chair, is here. She's agreed to present ahead of Alex McDonald.

Thank you very much for being here and we thank you very much for taking the time to come and talk to us this morning. As with all of the delegations, you'll have 15 minutes in which to make your presentation. You can use any or all of that for your presentation. If there's any time left, we'll have some questions and comments from the committee members. With that, the next 15 minutes are yours.

Ms. Valerie Bishop de Young: Thank you very much, and thank you for the opportunity to present today. I very much appreciate it.

Community support services are sort of the unsung components of the health system. We all know community supports when we need them, and we don't know about them very often until then: Meals on Wheels, for example; adult day programs for frail seniors, seniors and others with dementia; personal care and home support services; attendant care outreach and supportive housing services—these are for people with permanent physical disabilities. The spinal cord injury that is the result of the diving accident this summer is going to be our client in the next nine months.

In Champlain, there are 60 community support services throughout the geographic area, 11 here in the eastern counties, 24 in Ottawa, and Renfrew and county has 17. We are in pretty much every community across the province of Ontario. You may or may not have heard about us but we're very much alive and well in your constituency.

We serve thousands of people every week. Many of us have wait-lists for additional services and people who need it. We are members of the Ontario Community Support Association, OCSA. You may know us in your local community as Carefor, King's Daughters Dinner Wagon, Meals on Wheels, Rural Ottawa South Support Services, or le centre Guigues. The organization that I work for is VHA Health and Home Support.

I've provided you with a copy of a presentation. That's your take-away to think about. I recognize that I'm the last presenter and I'm the challenge between you

and lunch, but let's go through what community supports can offer you.

We believe that home and community supports work because they offer flexible, local solutions. That's what a progressive, modern health care system needs. You have to be responsive. People want to live and age in their own homes, not institutions. They certainly can't and don't want to be in the hospital any longer than they have to be. Hospitals are for acute care; let's keep them for acute care. Keeping people living independently in the community is cost-effective. It's efficient. Very little overhead goes into a community support organization. We help decrease emergency hospital admissions. We decrease long-term-care-home placements and long stays, and we do so at a lower cost to the health care system.

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The demographic horizon: What haven't you heard about it? We don't have to look to 2025 or to 2031 to know what the reality is. By the time we hit a year from now, 2015, there are going to be more seniors proportionally than children. From a taxpayer base, you've got to find the best way to make the biggest bang for the taxpayer dollar. As a taxpayer, I want to see you do that—and as somebody who is familiar with community supports, both because I work in the sector and also because I have aging parents. I'm sandwich generation: My parents are linked up with community supports so that at 83 and 86, they're able to stay in their own home.

Community is key. We work in the community support sector. We feel very much that LHSIA's foundational principles are strong and still stand: local planning and local accountability that respects regional differences. I'll give you some local examples of that. Across Champlain, there is one-stop access to attendant services for people with physical disabilities and for supportive housing. There is one point of access for adult day program providers, but that doesn't mean you can't go to the individual agency and say, "I need that help." Every door offers service. The Champlain transportation network helps people get to medical appointments so that they're not avoiding those medical appointments that are so important. We see increased collaboration—health links are a perfect example of that—and community supports are at that table.

All that is to say that LHSIA, the LHIN, has enabled community supports to be at the decision-making table, and we have not had that luxury before. Hospitals are there and long-term care is there, but as we age in this demographic, we're going to need people to be at their own home. You're going to need community supports. The LHIN legislation allows us to do that. This LHIN has been very supportive of having community support at the table. We're very grateful; it's the first time.

LHINs are not perfect—I'd be hard-pressed to identify any piece of legislation per se that is perfect—but we do not feel this is the time for change. Dissolution will cost money and it will cost time, and we have no better alternative identified as yet. Any review of local health

care has to acknowledge the interconnected structural challenges that are required to be overcome to develop and maintain a healthy population within the public budget.

Stability of the current structure is key. LHINs are increasingly responsive and, more so, engaged. LHIN strategies reflect local area interests and needs, and the LHIN responds to local taxpayer interests.

What, if any, improvements can be made? We can always improve. Improve coordination between LHINs and community care access centres. Improve coordination among LHINs, all of the LHINs, 14 of them in the province. Sharing information: What's the best recipe for a problem, a common situation? What are the wins? Engage and evolve primary care. Invest in community support services.

We don't believe that the challenge today is in restructuring existing legislation; rather, it's about supporting the needs that are greatest in our communities, in your communities. I listened with interest to the Arnprior hospital CEO, and I know him by reputation to be very involved and very community-focused. I would suggest that his desire to shift legislation so that the hospital can reallocate money into the community or elsewhere is probably unique. I just want to plant that bug, if I may.

There. I don't want to take up a whole lot of your time. We don't believe that there's reason to change the legislation, but there is reason to keep community support services alive and well and at the decision-making table. This legislation allows us to do that. This LHIN is very responsive in that regard.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes left, so we'll split that evenly—as evenly as I can. We start with the New Democratic Party: Ms. Gélinas.

M^{me} France Gélinas: Thank you so much for coming. I would say that the comments from the community support sectors have been very much in line with what you said. You're at the table; you're taken seriously. The valuable asset that you bring to community care is being recognized, and that has been a very good thing. We've heard that throughout the province, so—

Ms. Valerie Bishop de Young: Good to know we're consistent.

M^{me} France Gélinas: Yes, you are. My first question is this: There's some suggestion that we do away with local boards, so that the Meals on Wheels doesn't have its own board anymore, and the home support doesn't have its own board anymore, but moves either to a regional or a sub-regional board. Have you given that any thought?

Ms. Valerie Bishop de Young: We've watched with interest as Alberta moved to a fully regional board—in fact, a pan-provincial board—and are now devolving from that, going back to the regional boards. That sense of local flavour is unique. The GTA and Toronto cannot reflect what's happening in Ottawa, although they're large urban centres. Here in Champlain, we have the unique French component and a large rural component.

I'm not sure that regional boards can possibly be as sensitive as they need to.

Where the current boards of directors and those very committed volunteers have great value is in their willingness to reach out and talk to the LHIN boards and the LHIN staff and make those presentations and have discussions about regional needs.

Community supports are unique in that many of them specialize in certain services, so there's a special local interest and local flavour. I can certainly attest to the fact that many of those board members are very passionate about their community and what their service brings to them. A pan-regional or a regional body may be able to provide some of that, but the current structure doesn't cost you anything.

M^{me} France Gélinas: My second question is: A lot of the service you provide has a copayment attached to it. If you get Meals on Wheels, you have to pay seven bucks or whatever it is in your area. Is this well accepted by the people you serve: that people have to pay to access your services?

Ms. Valerie Bishop de Young: It is a barrier to accessing services for some, and some organizations have been very good about finding ways to fundraise to work with that. Our challenge is that the co-pay is different from organization to organization. It is not the same for Meals on Wheels here as it is in Thunder Bay or somewhere else.

The Chair (Mr. Ernie Hardeman): We'll have to cut it off there. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair, and thank you, Ms. Bishop de Young, for your presentation. Just to understand a little bit more about the Champlain Community Support Network: You have, as your network, all these individual service provider organizations.

Ms. Valerie Bishop de Young: That's correct.

Ms. Helena Jaczek: And then do you have your own board and you have reps from them on your board? I'm just trying to get a picture.

Ms. Valerie Bishop de Young: No. We are member agencies. We work for local agencies. We come together to collaborate, to share opportunities and to discuss where there are opportunities to improve services. There is no local board for the network. There are boards of directors for each of those organizations.

Ms. Helena Jaczek: And if a client phones one of you and the service may not be delivered by that agency, you can quickly—

Ms. Valerie Bishop de Young: Soft transfer.

Ms. Helena Jaczek: Okay.

How has the LHIN engaged your network in a formal sense? We've heard from one LHIN that they've created something called a health service provider council. Is there any structure like that here?

Ms. Valerie Bishop de Young: Very similar. I would say that the CCSN is very much like a council of community support agencies for the LHIN. The LHIN sits regularly at our meetings. We meet once a month. The LHIN provides input into discussions—very active. I

think the LHIN has actually enabled the community support network.

Ms. Helena Jaczek: And then do they bring you together with acute care facilities or other providers within the LHIN?

Ms. Valerie Bishop de Young: That is not their role at CCSN, but I think many of the organizations I know of that are in the community support network—we're all uniquely connected to our own primary care networks as we need to, as physicians and nurse practitioners want to be involved—community health centres, hospitals. The Going Home project in Ottawa is a perfect example of interconnectedness. The Champlain LHIN funds the Going Home project. It's run by a community support organization led by Carefor. Many of us are contracted partners or partners in it—

The Chair (Mr. Ernie Hardeman): Thank you very much for that answer.

Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Ms. Bishop de Young, for your presentation today—very informative. I'm interested in your recommendations, particularly the one about improving coordination among the LHINs. It seems to me that there is a large role for the Ministry of Health to play there, and there have been some presentations that have been made that suggest that the lack of an overall vision by the ministry is causing some consternation at the LHIN level in not knowing what the priorities are and what should be focused on in each individual LHIN.

I wonder if you could comment on that, and perhaps give us an example of where that is problematic.

Ms. Valerie Bishop de Young: I wouldn't want to speak to the vision. I think that on a practical basis, in a very pragmatic way, the LHINs are functioning quite well, as far as I've heard. Certainly I can attest to that here in Champlain. It seems to be working extremely well for community support services, and that's what I can speak to.

In terms of connectedness, I think there are opportunities to share our recipes for wins, as I call it. Integration is an example. I think there are a lot of opportunities where different community support organizations, community health centres, even hospitals, are coming together and looking at how we can work together. Integration is a mass of shades of grey along that spectrum. How do you do that? So we know that the Toronto Central LHIN has a huge cache of information about integration, and we're often cross-referred to get that. It seems to me that there's an opportunity, with all that expertise at each LHIN, to create a bank of resources. I'm speaking very pragmatically about the expertise that's available from across the province. How can we share that so that we can ramp up integration and opportunities for coordination a little bit better?

Mrs. Christine Elliott: So it's really about sharing best practices—

Ms. Valerie Bishop de Young: Yes, exactly.

Mrs. Christine Elliott: And allowing everyone else the opportunity to participate.

Ms. Valerie Bishop de Young: Yes.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time to come and talk to us.

Ms. Valerie Bishop de Young: Thank you very much.

The Chair (Mr. Ernie Hardeman): Our next presentation, I believe, is still not here. It's Alex McDonald. I didn't realize, when I mentioned last time that he was not here yet, that it wasn't time for him to be here yet. We had worked reasonably well forward with people who were here ahead of time. We have now passed the time that his delegation was to be here.

Mr. McDonald is not here yet? Well, then, that's the last of them before lunch, so I guess we'll stop there and adjourn for lunch. If he should happen by, maybe we can find some way to fit him in.

With that, we stand adjourned. The committee will have lunch here in this room.

The committee recessed from 1133 to 1327.

The Chair (Mr. Ernie Hardeman): Good afternoon, ladies and gentlemen. I think we're a minute or two from the starting time, but that makes up for all the times I've been late in my life, just once in a while being a little early. We thank you all again for being here this afternoon.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Ontario Council of Hospital Unions/CUPE: Doug Allan, research representative for CUPE. Thank you very much, Mr. Allan, for coming in this afternoon, presenting to us and helping us with our deliberations as we're looking at the LHIN review. You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If you have any time left at the end of it, we'll have some questions from our committee. With that, the next 15 minutes are yours.

Mr. Doug Allan: Perfect. It's a pleasure to be in Van-kleek Hill. I didn't expect to be here, but this is nice. I hope to present for about 10 minutes and to leave five minutes for questions.

The Ontario Council of Hospital Unions, OCHU, represents 30,000 hospital workers and long-term-care workers at 65 hospitals around Ontario. When the LHINs were first raised, we forecasted that there would be some difficulties; unfortunately, we feel that this has proven to be correct.

A number of problems have arisen, but two in particular stand out. First, they have been charged—quietly, perhaps—with centralizing, privatizing and cutting local hospital services; and second, they have distanced elected government officials from decisions to reduce, privatize or centralize local health care services. In other words,

they have allowed governments to avoid full responsibility for one of the most basic political issues, especially on a provincial level: access to health care, an issue that should be fully subject, in our view, to the democratic political process.

In this way, LHINs are like the Health Services Restructuring Commission of the 1990s. The HSRC took the flak for unpopular decisions to cut and centralize hospital services. That process, in our view, was very weak on public input, underestimated need, centralized services and resulted in bad outcomes, but did at least attempt to assess capacity and create some clear public plans for hospital restructuring.

With the LHINs, the planning process, to the extent it exists, is less clear and less consistent. There appears to be no consistent public attempt to assess capacity and need, or a plan to meet identified needs with adequate capacity. While capacity planning is weak, the changes we observe do certainly tend to follow certain very specific directions: centralization of services, the narrowing of hospital services, cutbacks, privatization, and the closure of smaller hospitals. Indeed, we believe there is a particular threat to hospital services in smaller communities.

The restructuring process used by the government and implemented by the LHINs is, in our view, more subtle and in some ways less transparent than the HSRC process. The LHINs have significant powers, it is true, and these were well noted when LHINs began to restructure health care, but they're seldom used, unlike the HSRC—that is quite a contrast—where the HSRC had very clear directions specifically set out, a lot of process involved in those decisions.

Unfortunately, it appears to us that the lesson learned from the HSRC experience was to keep the process out of public debate as much as possible. Instead, funding is the main tool that is driving the restructuring that we are currently seeing.

On the face of it, LHINs make major funding decisions for hospitals, long-term care, home care and other providers. However, the reality is different. Their room to manoeuvre is extremely modest. The 2013 budget indicates that funding for the LHINs actually increased by \$5.6 million. That is a 0.02% increase—two one hundredths of 1%. Indeed, over the last two years, there has actually been a \$310-million decrease in funding for the LHINs—a significant decrease, a 1.3% decrease. We sometimes call the LHINs the Dr. No of health care.

This is the major way that the government has driven the sorts of changes we fear. Rather than go through the process of public hearings, a public commission and public directions, the government has simply established regional arm's-length bodies which present health care providers with untenable budgets. The response, naturally enough, is to force regionalization and centralization and to abandon and cut health care services. Apparently—respectfully, we would say—it appears to us that it is more expedient to force the providers to do this and let them take the blame. Even when troubles do travel up

beyond the providers, the health care employers, they are often diverted—this is a constant discussion among health coalition people and union activists—on to the shoulders of the LHINs, which, frankly, we believe, have little room to manoeuvre.

Now we have significant restructuring with little public input and debate, and the pace of restructuring is quickening as we've gone through the last few years of very significant cuts to health care funding—real cuts. We've seen the removal of acute care services from smaller hospitals like Fort Erie and Port Colborne; the proposed or complete shutdown of smaller hospitals in the Niagara Peninsula, Shelburne and Burk's Falls; large cuts in smaller hospitals like Perth, Smiths Falls, Arnprior, Renfrew and Wallaceburg; the merger of the West Lincoln and Hamilton Health Sciences hospitals; the merger of the Rouge Valley Health System and Scarborough Hospital; and the merger of Credit Valley and Trillium hospitals all in process.

What have been the consequences of this funding policy for health care: a major reduction in complex community care and rehabilitation-weighted cases over the last two years. Ontario provides in-patient services to fewer than half the patients that other developed nations provide to their citizens. Tens of thousands of beds now have been cut over a long period of time—30 years. Bed occupancy is now at world-record levels. The English, for example, talk about a problem when it goes over 85% in terms of cancellation of surgeries, hospital superbugs and so forth. Ontario is significantly higher than that. There's some discrepancy over the figures, but the figures we've seen suggest about a 98% hospital bed occupancy level in 2010. Unfortunately, we sometimes hear from the minister that there will be more cuts of beds.

Ontario spends \$281 less per capita than the rest of Canada combined, including Ontario—a significant difference in terms of hospital spending: 19% more for all of Canada. The result? Nursing service is one key example: 3.6 hours less nursing care per weighted case—that's a typical patient—than the Canadian average. That was in 2007-08. It has gotten worse: We've reduced it by a further 2.1 hours, while the rest of Canada has gone up, so now the gap is an astonishing 6.1 hours per weighted case.

Not surprisingly, this is driving very much higher what they call nursing-sensitive events—medical errors, essentially, on the nursing side—5.1% higher in Ontario. Well, it's not surprising. With 6.1 less hours of care, there are going to be more errors.

There's also a very significant move to shrink hospitals only to in-patient acute care services. People sometimes talk about this as the natural process of what hospitals do, but in-patient acute care services are actually a small part, a major but small part, of hospital services—a minority part, I should say. Some 37% of funding for hospitals goes to acute care services. Reducing back to that level will threaten the viability of hospitals around the province, especially in smaller communities.

There have been, in contrast, significant increases in other areas, notably OHIP, primarily covering doctors. In the 2013-14 budget estimates, OHIP went up 2.9%, to \$13.3 billion. They got a 2.9% increase. The rest of the health care system, including LHINs, got, on average, a 0.3% increase, just over one tenth as much. Some \$374 million of that increase, according to the budget estimates, went to OHIP, which primarily covers doctors, whereas the total health care increase was \$486 million—three quarters of the increase. It's part of a long-term pattern. Ontario spends more per capita on doctors than the other provinces, and 6% more than the Canadian average, whereas we spend significantly less, as noted, on hospitals.

As an immediate step, the real cuts to public hospital funding need to stop. Funding should increase to the Canadian average. Over the longer term, the government, in conjunction with the regional health authorities, wherever they may be, should publicly develop capacity planning by identifying the current and future health care needs of local communities as well as the existing bed and service capacity in the hospitals, the long-term-care facilities and in home care. The identified health care needs should form the basis of capacity development to these health care subsectors and be part of the public debate on how to achieve that and what those levels should be.

Privatization: This is becoming a dramatically increasing role for local health integration networks in the period ahead. The government has identified that it wants, as part of these changes that we've talked about, to move more public hospital services out to private clinics; in particular, surgeries and key diagnostic work. Again, that's a significant threat to community hospitals, especially in smaller communities. Already, it is effectively closing down community hospitals by moving core work over to private specialty hospitals or specialty clinics. That threat has deepened. Such clinics will only seek to provide services where they can make money. Instead of being able to provide a range of services, community hospitals will see more and more of their services creamed off, leaving them with the most difficult and least profitable. This was an issue in America about a decade ago and led to a freezing of their work.

Quality: Operations can and do go wrong. The main response of the specialty clinics that we've seen so far is to call 911. They don't have emergency capacity to deal with this, typically. Will ambulances be able to move patients to hospitals when things go wrong? These are surgeries, after all. Indeed, private surgical clinics first came to the public's attention in Ontario when a patient died and the paramedics arrived to find the patient with no vital signs.

Is it appropriate to establish a system that inherently requires extra time to effectively treat patients who will fall into emergency situations? Inevitably they will. Will the hospital government establish a requirement that doctors be on site at all times? Will they require that specialty hospitals have emergency capacities beyond

calling 911? Will they require that private clinics disclose to patients the limitations they have on their ability to provide emergency services?

Oversight: The government has quickly passed the buck over to the College of Physicians and Surgeons. This, we find, is odd because it was the doctors who had actually lobbied for this development. They have provided only very limited information. Typically, their public review of the clinics is one word: “Pass.” That’s all we get.

User fees: The Ontario Health Coalition has revealed widespread extra billing by existing private clinics. There’s little doubt that this will intensify with more private clinic delivery. Already, Ontario has a very high—the highest—amount of private payment for health care services in the country, about \$100 more per person than the rest of the country, including Ontario, combined.

There have also been significant problems with questionable billings. The government just went through a very extensive fight with private physiotherapy clinics this past summer—a major struggle. The government reported that they did not have proper billings for most of their billings information. In Quebec, just across the border here, we had Rockland MD that was shut down because they were billing for things that weren’t appropriate—a major concern for us.

OCHU, with the Ontario Health Coalition and others, will be going door to door to stop the transfer of services from public hospitals to private clinics. That will happen in the months ahead. We need to stop the transfer of hospital, surgical and diagnostic work from public hospitals to private clinics. LHINs should be forbidden from transferring work from public hospitals to private providers.

With that, thank you for your consideration. I hope I left a little bit of time for questions. I may have blathered on a bit too much.

The Chair (Mr. Ernie Hardeman): Actually, we’re at 14 minutes and 14 seconds. So we have reached the end, and we don’t have time for questions.

Mr. Doug Allan: I’m sorry; that was not my intention.

The Chair (Mr. Ernie Hardeman): We are here to hear you. Thank you very much for your presentation, but that does conclude the time.

Mr. Doug Allan: Thank you.

The Chair (Mr. Ernie Hardeman): The next presenter is Perley and Rideau Veterans’ Health Centre: Akos Hoffer, chief executive officer.

United Way Centraide Ottawa: Michael Allen?

He’s not here either yet, so we’d better take a break.

The committee recessed from 1343 to 1343.

PERLEY AND RIDEAU VETERANS’ HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): We’re reconvened.

We want to thank you for coming and even more so for being early for your appointment so we can hear you early. Secondly, it also provides me with the opportunity to lay out the ground rules without repeating myself. You haven’t heard them before because you weren’t in the audience as I’ve done it for others.

Mr. Akos Hoffer: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): I usually start off by saying, “As you’ve heard me say before,” but you haven’t. You will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there’s any time left over—more than a minute—then we will have questions or comments from the committee. With that, starting now, it’s your 15 minutes.

Mr. Akos Hoffer: Thank you for having me here. I really appreciate the opportunity. And thank you for scheduling the hearing on such a beautiful day; it makes the commute a little easier.

I’m assuming you’ve had one person after another come here and recommend that you go to Beau’s brewery, so I’m going to lend my voice to that recommendation.

Ms. Helena Jaczek: We’ve been.

Mr. Akos Hoffer: Oh, good, you’ve been there.

The Chair (Mr. Ernie Hardeman): They’ve been researching the topic.

Mr. Akos Hoffer: Good.

I didn’t submit a CV, so maybe I’ll start by introducing myself. I’m Akos Hoffer. I’m the CEO of Perley and Rideau Veterans’ Health Centre, and I’ll talk about who we are a little further in a minute. I’m also the co-chair of the Champlain Dementia Network steering committee, which is an organization that provides guidance to the Regional Geriatric Advisory Committee, which is one of the committees that advises the local health integration network on its work. I’ve been with Perley Rideau for about six years now and with the Champlain Dementia Network just this past year.

Who Perley Rideau is: I should talk about what our relationship is with the LHIN. Essentially I think of us as their client because they provide a great deal of our funding. Perley Rideau is a 450-bed long-term-care facility. We also have recently constructed 139 seniors’ housing apartments and introduced some new programs such as the assisted living services for high-risk seniors program, many of those done in consultation and partnership with the local health integration network.

I would like to speak to integration, as that is one of the foremost responsibilities of the Champlain LHIN. Our orientation at Perley Rideau—again, because we have essentially a client relationship with the LHIN—is to think about how we can be most responsive and most valued by the LHIN and the citizens of Ottawa.

A lot of our work and a lot of our planning in the last year has led us to think about this: If you think 15, 20 years out, what are the trends that are really pushing the health care system and how can we be most responsive? In fact, our response has been to become more integrated

as an entity. Some of the things that we've been able to do are, for example, to expand our convalescent care program, which helps people return home from hospital rather than staying in the hospital. That's one of the benefits of that program. Another is, we rolled out an assisted living services program that is available to members of the community but also to seniors living in our new apartments. All of this work was done, again, in very close consultation with the LHIN. What they brought to the table, really, was high-level direction. A few years ago, we were developing our strategy and at the same time the province and the LHIN were developing the Aging at Home Strategy, so the two met and we set our own strategy going forward.

I would argue that it's very difficult to do this kind of work without some really strong local planning expertise. Certainly, I would say that that's where the LHIN has been able to help us—number one, through engagement. It's not just with the staff but also, for example, committees like the Champlain Dementia Network steering committee that really engage the local health care community and consumers of health care in trying to develop solutions to some problems. One obvious example is alternate-level-of-care, which is a very significant concern for hospitals; it has been for a while. If you go to the steering committee that deals with that issue, you will see some very highly engaged local health care leaders who are trying to find ways to solve a complex local systems issue. Certainly, the LHIN supports that process by chairing the meetings but also by providing good data and creating accountability with all the players around the table in various ways. I think that's classic performance management. That's something we try to do within our own organization and it's something that has certainly yielded results when it comes to alternate-level-of-care.

The other thing I would talk about is, if you think about the LHINs as venture capitalists or angel investors, they obviously are there to execute the strategic direction of the Ministry of Health and Long-Term Care, but clearly there's some latitude there and there's some judgment and decision-making that can take place at the local level.

I'd like to give an example of this. Recently—about a year ago—a group of us developed a study that came out with an integrated model of dementia care. What this strategy does is it really talks about a consumer of health care who is coping with dementia and their family—and the number of these people is going to increase in the years to come—and talks about how they access services for dementia care and how the care providers can co-ordinate their care, because it's quite complex, and especially if your cognition is impaired, it gets more and more difficult.

1350

This was a strategy that was funded by the LHIN in terms of the development. There was a mandate given to a small group of providers to develop that strategy. It was submitted to the LHIN; it was accepted. Now the planks

of that strategy are being funded as well, so we're very pleased to see that. Part of that is an awareness campaign so that people can become more educated about the resources available to them. Others are changing the way clinicians provide care to persons with dementia. It's based on evidence and on leading practices throughout the province, so we've been very pleased to be part of that.

The other part that I'll mention is advocacy. I'm fairly new to my role—I've been in the CEO role for about six months now—but I can already see where there's the potential to work with the LHIN to help our local issues become known by the provincial Ministry of Health. This is important because the LHIN finds itself in a situation where it has latitude over some decisions, but not over others. Long-term-care funding is distinct from hospital funding, and some of the rates and per diems and funding levels are set centrally. For some of us, for an organization the size of Perley Rideau, that is going to cause some challenges fairly soon. What we see is an opportunity to work with the LHIN in partnership to gather data about local needs—so what will the need for long-term care and other types of care for seniors in the community be—and then try to determine whether the funding for that type of care is adequate and whether we can function within that funding envelope. If we can't, personally I see an opportunity to work with the LHIN to bring that forward and to work in partnership rather than going it alone, as it were, as an organization.

I'll end by just touching on one recommendation. I assume you're hearing lots of recommendations and possibly even some criticisms. The one recommendation I would have comes to planning. If you look at Perley Rideau, our own strategic plan started off by looking out 25 years. We ended up developing a plan that runs from 2010 to 2015, so it's a 15-year plan. This is fairly unusual in health care because of all the dynamics. Obviously, health care, health care funding, health care policy is subject to political influence, so there's uncertainty on a regular basis. Some providers are reluctant to look out on the horizon, but we have to. We really have to because the infrastructure and the planning take so long to get into place that what I'm worried about is that if we don't take a longer view, we're going to find ourselves responding or reacting rather than planning.

The LHIN has obviously a strategic plan; however, it is limited to three years. I would dearly love to support longer-range planning at a local level, even if we don't know the answers, even if we don't have certainty. It really has been very compelling for our organization to set a vision that's way out in the future, recognizing that some of the strategies and some of the plans may need to change as time goes by, but it's amazing how time flies. I'll end there.

The Chair (Mr. Ernie Hardeman): Thank you. We have about five minutes left, so we'll start with the government. Mr. Fraser.

Mr. John Fraser: Thanks, Akos, for your presentation. I'll have to say a little plug: Perley Rideau veterans

is in my riding of Ottawa South and they're a great organization.

I'm very interested in what you have said about long-term planning, and I think that's a very important point. But I want to go back to something we've been hearing. Primary care: Something we've been hearing throughout the hearings is in terms of the LHINs having more connection or impact or control over that. Can you speak to that in terms of your work with the dementia network, how you would see that?

Mr. Akos Hoffer: Sure. With the dementia network, some of the work in the integrated model for dementia care calls for a model that was developed by Dr. Linda Lee—I believe she's out of the Waterloo area—that is really backed up by evidence in terms of how clinicians—how family doctors, really—can better diagnose and provide care for persons with dementia. Right now, if you go to your family doctor and you are suffering from dementia, it's not as consistent as it could be. The knowledge is not as high as it should be.

But to me, it's a very low-cost way of improving the expertise of people who are already there. They already have a roster of patients, and there's a system that has been developed where you take these clinicians, you train them, you set aside time in their schedule to diagnose for dementia, and then that model can be sustained over time as well, and expertise can be developed.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for appearing before the committee and for stepping up so quickly. We appreciate it.

Mr. Akos Hoffer: You're welcome.

Mrs. Christine Elliott: I'm also really interested in the concept of planning and the advocacy role as well. We have heard some presenters and some people who work in the fields of dementia—Alzheimer's and so on—talk about the tsunami of Alzheimer's that's about to overtake us, and what they perceive as being a lack of planning, frankly, on the part of the Ministry of Health, to really prepare for this.

What do you think the ministry could or should be doing now, working with the LHINs, in order to advance this planning?

Mr. Akos Hoffer: To be honest, I think they're doing it. The LHIN will say this—we can't put it all on the LHIN; I mean, there's a handful of people working there. What they will say to us is that it's the providers like Perley Rideau, the hospitals and other organizations that really have to do the heavy lifting. In fact, in our accountability agreements, we're held to account for planning for integration.

I think the challenge is there. The models, like the integrated model of dementia care, set it out. Now it's just funding it and really making it a priority. I think that's where the long-range planning will become really important, because we'll be able to see, if the seniors population is going to double in the next 15 or 20 years, really, what the capacity is that we're going to require for

long-term-care beds versus convalescent care beds versus community support as well, which also needs to grow. Providing that kind of information to the community, to the people who are accountable to help integration happen, I think, would be very, very helpful.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^{me} France Gélinas: You've touched on it, but very briefly. You've mentioned that you have 450 long-term-care beds, 139 housing units, and you have some assisted living.

Mr. Akos Hoffer: Correct.

M^{me} France Gélinas: Is your assisted living being financed by CCAC or by the LHINs?

Mr. Akos Hoffer: It's by the LHINs.

M^{me} France Gélinas: It's by the LHINs. So my question to you is that some presenters have talked to us about why is it that the community care access centre continues to fund agencies when the LHINs are already set up to do that kind of thing? Because you know as well as I do that community care access centres will fund services to provide assisted living, and we have the LHINs that fund services to provide assisted living. Why do we need two bureaucracies to do the same thing? Do you have a comment on that?

Mr. Akos Hoffer: Well, in terms of assisted living services, there's a contract that's signed with us to deliver that. The advantage, from my perspective, in having a Perley Rideau or a Bruyère provide this kind of care is that it sets the stage for a warm transition, so you get to know, potentially, your future residents and then carry on that relationship over time. That has been tremendous. It's our own staff that we deploy to provide care in the apartments and in the surrounding community.

The same way, we've put a proposal in to the LHIN to establish a primary care clinic on our campus with the South-East Ottawa Community Health Centre. It's a similar concept. It's getting to know the consumers of health care better.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time. We very much appreciate not only your coming, but your willingness to sit down on such short notice to give us your presentation.

Mr. Akos Hoffer: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): That recess we just took a few minutes ago, we are really going to take it now.

The committee recessed from 1359 to 1412.

UNITED WAY/CENTRAIDE OTTAWA

The Chair (Mr. Ernie Hardeman): We thank you very much for being here. We'll just give our committee a moment to find their chairs again.

We have Michael Allen here, president and chief executive officer of the United Way/Centraide Ottawa. Thank you very much for being here this afternoon and taking the time to come out and talk to us. You'll have 15

minutes in which to make your presentation. You can use any or all of that time for the presentation. If there's any time left over, we'll have some questions from the committee.

With that, your 15 minutes starts right now.

Mr. Michael Allen: Thank you very much, Chair, and I apologize; we had timed our travel to get here just in time, and of course, I should have realized that you were running early. Normally when I come out this way, I have three teenage—some of them are more than teenagers, and we always make our beeline for the hockey rinks. We allow enough time to change. Anyways, I didn't factor that in. But thank you very much for the opportunity to appear before you and to speak a little bit about the United Way of Ottawa and its relationship with our Champlain Local Health Integration Network. I hope it contributes positively to the review that all of you are undertaking. Thank you for visiting our region.

Let me offer a bit of a context for our presentation today. Most of you, I hope, would be aware of the United Way movement across our nation. The United Way of Ottawa is no different in that over the last number of years we have undergone quite a profound transformation in terms of our work. I won't bore you with all of its details, but I will speak to some of the characteristics of that transformation; they'll be familiar to you. They were born out of a sense that the work that we were doing in terms of fundraising and investment was not sustainable in and of itself, that we had to begin to focus on priorities that we felt were the most important and where we could have an opportunity to make an impact and a contribution. As well, we recognized that the work that we undertook, in terms of our desire to effect community change, could not be done alone. We had to reconcile that, in order for us to be successful in terms of the ambitions that we had, we had to work with others.

In that regard, I'll speak to some specific examples of how we found in the LHIN a very willing and helpful partner. Again, it won't be a surprise to you that while we identified the goals where we felt we could have an opportunity, unlike many issues in our communities, we found that the lines between health and community services and human services were blurring. So we found ourselves intersecting, in many areas, between the work of the local health integration network, the provincial government and the work that we do in terms of the community sector. I want to bring to your attention at least two of those examples, and I believe they speak to the kind of characteristics that the LHINs were designed to address. The first is flexibility and nimbleness to local community dynamics; the second is the ability to calibrate, within a region, the community capabilities and the institutional capacities that exist and the ability of this arm of the provincial government to be sensitive and calibrate accordingly.

The first example that I want to offer to you is one that I know at least one of your committee members will be intimately familiar with. We've worked with him

throughout the years on it. It's a project that we refer to as Project STEP—support, treatment, education and prevention—and it speaks to the issue that we were faced with in our community about local youth drug addictions. Today, in Ottawa, 57 secondary schools across all four school boards and a number of non-mainstream academic settings for teen mothers, street youth and aboriginal youth have access to school-based substance abuse counselling and supports. Left unchecked, you'll all know that youth addictions can have devastating consequences for everyone: crime, underemployment or unemployment, hospital care, homelessness. To intervene requires crossing government jurisdictions, sectors, professional boundaries and resource requirements. We found, as I mentioned earlier, a very willing partner with the local health integration network, but that partnership did not end with just ourselves and the LHIN. It included the private sector organizations like the Ottawa Senators Foundation; it included the city of Ottawa, through its public health authorities; and it includes all four school boards. All of us are equal funding partners for this work that now covers 57 secondary schools across our region. The result is that as of today, we have two facilities that deliver residential drug treatment, but probably more importantly and upstream, we have this service in the schools.

We can report some results to you as a result of this work. Three out of every four students were able to reduce or stop using one or more drugs in less than one school year, as our stats indicate over 2013—and a significant decrease in use, or abstinence. Students who were experiencing moderate to severe difficulty upon entering school showed notable improvements in health and well-being. Some 6,200 students in our school systems participate in prevention education sessions, and 1,600 of these were connected with counselling. Probably most significantly—and certainly a metric that we are disciplined about measuring, and I suspect that organizations like the LHIN will be equally committed to that—is that 92% of the students who were admitted to the counselling programs stayed in school and finished their school year. As I say, the local health integration network, together with business, together with school boards, committed to this work, and the flexibility and nimbleness that our LHIN demonstrated made them a very active and important partner for us.

The other example I want to leave with you is the role that I believe, at least, through the lens that I have, that our LHIN supported is its ability to calibrate. One of the dynamics I know that is alive and a debate that's alive, which I don't fully appreciate—only you folks will fully appreciate it—is the requirement for both the community sector and the health care institutions like hospitals to play. The LHIN, we believe, is capable, particularly on a local basis, of calibrating that accordingly. An example of that for us has been in our area of aging in place for seniors—the ability to keep seniors, with dignity, with supports, in their homes and not in institutions, where it's unnecessary. There are a number of examples that we can

speak to. The one that I will speak to is, again, a dialogue that we have had with the LHIN around Rural Ottawa South Support Services. This covers a number of more rural parts of our community—Manotick, Greely, Osgoode and Rideau—and again, it was an opportunity for us to work with the LHIN where we complemented our respective services and funding support.

1420

For the LHIN, they began to engage in the support through organizations around the transportation network, to make sure that seniors, for example, could get to their hospital appointments.

Where the United Way stepped in with funding—because of that—was around social recreation: keeping seniors active and healthy. Again, a nice opportunity to engage and complement and calibrate the relationship between the institutional supports and community supports within the community where different funders could play different roles. For us, these things have been tremendous characteristics that the LHINs have brought to our work. They have provided a great place for us to have a conversation about what role the community sector can play, what role another funder can play, together with what role a government entity can play.

The final area that I'll speak to—and this is not so much a local dimension but nevertheless something that we have found tremendously helpful from our local LHIN—is, generally speaking, the drive that we see within all levels of government, the provincial government being no different, and one that we have embraced for the community sector, and that is accountability and measuring results, measuring impact. The LHIN, I believe, has continued to embrace that within the institutional setting, with hospitals, but that is beginning—and, I believe, out of necessity and absolutely an appropriate thing—in the community sector as well. Work that we have been able to do together around services like 211 and our local work around the Ottawa Neighbourhood Study have been examples of that.

We will be submitting a written submission to your committee; we'll outline that a little bit more, but we continue to commend the provincial government and the LHIN to encourage that discipline, that accountability, that transparency of the voluntary sector. That's a great help, and frankly, we believe it's an important thing for the community sector to be able to step up to.

Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We just have a touch over five minutes. We start this time with the official opposition. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your presentation today and for the great work that you're doing in your community. I'd particularly like to congratulate you on the success of the STEP program. It sounds like it has been really doing great work with young people.

I'm wondering, because one of the presenters earlier today said that there's an opportunity for the LHINs to

get together to share best practices: Have you been able to speak to other LHINs about the success of your program? Are any of the other LHINs sort of following the lead that you've taken in this respect?

Mr. Michael Allen: I'm not sure I'm capable of answering the latter part of your question, Ms. Elliott, but I can say that we've been very flattered to have folks from the LHIN and from the provincial government, and frankly other organizations nationally, which have recognized with awards the work of Project STEP. Without being boastful about it, we are very proud of the results that we have received.

I suspect you'll be familiar with the term "collective impact," which describes a collective impact model for our community, where organizations and funders get together to agree on objectives, to agree on measurements, to agree on strategies to complement towards a specific goal. I'm not sure about the LHINs themselves, but certainly we have received generous attention from the provincial government, the Ministry of Health in particular, about this model and the struggles of perhaps replicating it. I know it exists there, but certainly we're aware that there's an appetite to see that kind of activity.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^{me} France Gélinas: I don't know if you'll be able to answer, but I'll ask you anyway. The same with me: I want to congratulate you for the great work that you have done.

Some of the presenters earlier on talked about some of the historical disparities, as in the money that is flowing to the Champlain LHIN, given the population, the complexity and the type of tertiary services you have, versus, let's say, Toronto Central. Historically, there are some significant differences between the amount of money that comes to Champlain versus the other LHIN. How would you suggest that we address some of those historical disparities now that we have this regionalization?

Mr. Michael Allen: You're right, Madame Gélinas: I don't think I can address that, although I'm going to make a note of it. But I guess I would address it slightly differently, and that is that one of the benefits of a local entity with that macro perspective is being able to bring a sensitivity to the capacities within each community, because they are distinct. We sense it even here. Between Ottawa and this part of our region, there are tremendous disparities. We sense it within the community sector, and I understand now that you're saying you sense it within the province as a whole.

One of the benefits of what the LHIN has brought to us is an understanding, a respect, a sensitivity to capitalize on those distinctions and build and, in turn, share with organizations like ours, frankly, the responsibility that we have for our entire region. So I think that's a helpful way to begin to address some of those disparities.

The Chair (Mr. Ernie Hardeman): Mr. Fraser.

Mr. John Fraser: Thank you very much, Michael, and thank you very much for mentioning Project STEP. I think it's something in Ottawa we're all very proud of

and it has been very successful. We've managed to, I think, replicate it in some sense around suicide prevention—start with something and have it grow, and it is growing.

The question I want to ask you is more about the social determinants of health, because I know that that's something that is of key importance to your organization. Dr. Keon mentioned it this morning. What do you see, going forward, for the LHINs with organizations such as yours?

Mr. Michael Allen: Well, John, first of all, I know this is not the forum for it, but I will just tip my hat to the support that you offered for Project STEP. I think it's indicative of the kind of thing that MPPs do in their ridings, and your previous role in an MPP's office was very helpful.

I think it speaks, John, to the kind of intersections that we see. It used to be that the United Way would be fairly rigorous about our sense of, "We're involved in the community sector, not the health sector." Those lines are blurring now significantly. Our work in mental health, as you point out, our work with addictions, our work with seniors' supports—those things all intersect in terms of the care of our neighbours, of the people who live in our communities. The more that an organization like our provincial government, whether it's through LHINs or through any other structure, can be sensitive to and work with the capacities that are within the community sector—I think, as a going-forward proposition, that's what we're facing. We would look forward to ongoing dialogue with organizations that adds capacity to communities.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes your time. We very much appreciate you taking that time to come and talk to us.

Mr. Michael Allen: Thank you, Mr. Chair. My pleasure.

EASTERN ONTARIO REGIONAL LABORATORY ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is Eastern Ontario Regional Laboratory Association: Craig Ivany, chief executive officer, and Bernard Leduc, chair of the board.

Good afternoon, gentlemen. Thank you very much for taking the time to come and talk to us today. As with previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that for the presentation. If there's any time left over, we'll have some questions and comments from our committee. With that, the next 15 minutes are yours.

Dr. Bernard Leduc: Thank you very much, Mr. Chair. Thanks, and good afternoon. My name is Bernard Leduc, and I'm here as chair of the board of directors of the Eastern Ontario Regional Laboratory Association, EORLA for short. I'm here today with Craig Ivany,

EORLA's CEO, to present our recommendations regarding the Local Health System Integration Act.

EORLA is the largest voluntary integrated medical laboratory in Ontario. As such, it's one example—probably the most important one—of integration of health services in Champlain since the introduction of the Local Health System Integration Act that saw the creation of the LHINs. We will be presenting on the history behind the creation of EORLA and what role the LHIN actually played as a catalyst that saw 16 hospitals come together to create this integrated medical laboratory service.

Although long in its gestation, EORLA is still young in its history as a functioning entity, only coming together as of April 1, 2012. I can state that the support of the LHIN has been an important key factor to our success. Thank you for allowing us to do the presentation.

Craig, I'll pass it to you now.

1430

Mr. Craig Ivany: Thank you, Bernard. Good afternoon, and thank you for the opportunity to address your committee.

The Eastern Ontario Regional Laboratory Association—we call it EORLA—is a member-based, incorporated, not-for-profit organization delivering high-quality, cost-effective and safe medical lab services. EORLA membership comprises the 16 acute care hospitals within the Champlain LHIN. On April 1, 2012, the 16 member hospitals turned over the operations of their medical laboratories to EORLA, and at that point, EORLA became the largest voluntary integrated laboratory in Ontario.

While April 1 was the first date of operation, the concept of laboratories working together in eastern Ontario dates back to the mid-1990s. The partnership between the Ottawa Valley Hospital laboratories and the Queensway Carleton Hospital lab was one of the first collaborations of its kind in Ontario.

The eastern Ontario laboratory coordination program, the precursor to EORLA, was based on the concept of labs working together for mutual benefit. In 2000, the laboratory branch of the Ministry of Health and Long-Term Care mandated all Ontario laboratories to participate in group strategic exercises and prepare regional plans for the delivery of lab services. The first business case for EORLA was prepared at that time. The Eastern Ontario Regional Laboratory Association was registered as a not-for-profit organization in 2003 and consisted of 16 member hospitals. This was one of the first major initiatives to implement a coordinated, regional business model for hospital labs in Ontario.

During the period from 1998 to 2006, hospitals experienced a 45% increase in the number of lab procedures, requiring an annual increase in costs of 6%. At that time, it was projected that without some form of intervention, the region's hospitals would be faced with the challenge of unmanageable laboratory costs.

Simultaneously, EORLA established a successful partnership agreement with Gamma-Dynacare Medical Labs for the provision of expert resources, purchasing

agreements and management services. In 2005, the EORLA board retained Gamma-Dynacare's services to prepare an updated business case. The ministry followed up with a third party review of the 2005 business case and the infrastructure required for the delivery of quality patient services. QSB Consulting conducted the review and released a report confirming the value of the integrated laboratory model.

Concurrently, Ontario introduced the Local Health System Integration Act, which created the local health integration networks. The inaugural Champlain LHIN CEO, Dr. Robert Cushman, engaged the LHIN in furthering the EORLA concept.

During the period from 2006 to 2008, development focused on the many elements of creating a sustainable organization and determining the optimal models for all aspects of the business, including governance, leadership, medical and scientific, human resources, quality assurance, administration and financial. Cost-containment initiatives commenced through the regional standardization of test platforms and supply contracts. At this time, the LHIN emerged to play a key role as funding agent, change agent, integration champion and mediator to support the building of an acceptable model for all members.

The concept of regional lab service delivery has been gaining global acceptance over the last decade. Drivers for integration include health system happenstance and laboratory medicine industry factors. The typical pressures of the health system include financial sustainability, access, quality improvement and demographic changes.

The global trends in lab medicine further accentuate the need to consider alternative business models. These elements include technology development and complexity, aging workforce, point-of-care testing, the explosion of genomics, the promise of personalized medicine and the need for substantive information management to bring all elements together.

The reality beginning to emerge is that without substantive ongoing investments by individual hospitals, laboratory services will quickly lack capability to respond to the changing demands of the health system. Therefore, the foresight of the leaders in eastern Ontario to investigate regionalized laboratories in the mid-1990s has been subsequently validated by the evolution that is presently occurring in lab medicine.

During the period from 2009 to 2010, EORLA continued to move through the work of structuring its model. One of the key challenges during this period was project fatigue and the emergence of turf protection, causing the target date for implementation of April 1, 2009, to be pushed to April 1, 2010, and beyond.

At this point, financial commitments were made in support of the integration by both the Ministry of Health and the Champlain LHIN. The ministry provided \$2.7 million, and the LHIN provided \$1.86 million in funding to EORLA between 2009-10 and 2013-14 to cover the transitional and one-time cost of integration.

Supported by this financial commitment, key leadership from the LHIN and hospitals facilitated the future of EORLA. The EORLA board of directors was renewed with hospital CEOs appointed as board members and the ultimate decision was made to proceed with the EORLA model on April 1, 2012.

It was clear that a change in the current methodology behind lab operations was essential for survival, and that full implementation of the EORLA model would ensure sustainable, high-quality, cost-effective and responsive laboratory services in the future. A series of legal agreements defining the transition and ongoing operation model were executed by all EORLA member organizations in early 2012. The LHIN also played an instrumental role through the inclusion of performance obligations within the hospital service accountability agreements for the acute care hospitals to commit and participate in EORLA. This was an important means to encourage the move forward as an integration of lab services. The HSAA condition remains in place to encourage continued commitment by the member organizations.

On April 1, 2012, some 850 lab technologists and technicians in 19 sites across the Champlain LHIN were reassigned to their new employer and the laboratory operations commenced under EORLA's banner. EORLA has continued to progress as an organization with a number of key achievements:

EORLA board of directors has moved through a period of renewal culminating in the appointment of three community-based members.

EORLA lab quality has been maintained through the transition and stabilization periods and work has now begun on revising and enhancing the quality metrics.

EORLA has successfully standardized lab testing platforms across the network, specifically in haematology and biochemistry.

EORLA will have transferred 75 medical and scientific staff from five hospitals by March 2014.

EORLA has exceeded the business case savings objectives and has also maintained a zero per cent increase in lab costs to members for 2012-13 and fiscal 2013-14. Budget projections for 2014-15 hold a zero per cent growth for lab costs to members.

EORLA has successfully completed consolidation and improvements in processes that have delivered improved costs, quality and timeliness of its services to its members.

EORLA's structure and critical mass enable the organization to become more innovative and effective in the delivery of high-quality lab medicine to its members.

EORLA is currently pursuing implementation of cutting edge technologies such as:

- full lab automation, mass spectrometry and next-generation polymerase chain reaction testing for MRSA—methicillin-resistant staphylococcus aureus—in microbiology;

- looking at PCR testing for the flu virus in virology;

- the development of molecular oncology diagnostics in anatomic pathology; and

—regional automated slide imaging in haematology.

EORLA represents a unique approach to health system integration. It represents the best principles of collaboration and has moved from concept to operation by the collective will of the hospital leaders within the Champlain LHIN, the support of the Champlain LHIN and the support of the Ministry of Health. The model embraces the values of the Ministry of Health by delivering patient-focused, results-driven, integrated and sustainable laboratory services to its members today and into the future.

We'll close with the two recommendations that we would present for consideration.

Recommendation 1: EORLA supports regional planning and recommends the continuance of the Local Health System Integration Act. Health system integration, done well, can lead to improvements in care delivery and sustainability while respecting the unique offerings of individual elements of the system. The presence of an integrative agent, such as the LHIN, neutral to the various agencies, provides the right environment to move new initiatives forward.

Recommendation 2: EORLA recommends that the LHIN continue to be a key funding source to seed planning and integration initiatives. The LHIN has a capability to seed the full system delivery needs within the local region and can facilitate priority integration opportunities through targeted funding.

Thank you very much. Merci beaucoup.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have just over four minutes left, so we'll start with the New Democratic Party for a minute and a quarter.

M^{me} France Gélinas: Use them wisely? Thank you so much. Just a very quick question: You really feel that after all the work that you had put, it was because the LHINs were there to give the last push to get you through the finish line?

Dr. Bernard Leduc: I think it was instrumental in terms of getting the focus and getting the ball rolling. There had been discussions for many years. Change in leadership at the board level also made the movement important. But again, putting it in the accountability agreement of the hospitals to participate and see EORLA come to fruition I think was a key component.

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M^{me} France Gélinas: Do you ever see you going into community labs?

Dr. Bernard Leduc: It's something we're doing a strategic plan on right now, and thinking about.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: How do you explain the fact that you did have, between 1998 and 2006, a 45% increase in the number of lab procedures? Were there duplications occurring between facilities?

Dr. Bernard Leduc: There was growth, just expansion from some of the services happening in that particular time, but also lab medicine. Medicine relies more and more on laboratories, so one of the key components

where, actually, we haven't seen the benefit of the regionally integrated model is looking at utilization and using that expertise, not just in one hospital but across the sector.

Ms. Helena Jaczek: So have you centralized in one lab? Have you taken the labs out of the 16 hospitals and had one centralized lab, so that you can share equipment? Why is this so good?

Dr. Bernard Leduc: There is a centralization of one big lab, but each bigger hospital—the 16 hospitals do have their labs. We're in a period of consolidation right now and looking at what would be the best practices in terms of consolidating, but what you get is a normalization of the standards and the quality across all 16 hospitals at the board.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mrs. Elliott?

Mrs. Christine Elliott: Your second recommendation talks about the LHIN needing to continue to be a key funding source. Some of the presenters have indicated that they have a few problems with the way the funding is operating, and have expressed a wish that funding could maybe be retained and saved for further projects down the line. Do you have any experience with that, or any comments you'd like to make on how that might be improved, perhaps?

Dr. Bernard Leduc: Funding is for the fiscal year. That's the rules that the LHINs are operating in right now. I'm sure that, if there are some efficiencies in the system, retaining them for the benefit of the whole system would be something that we would consider positively.

Mrs. Christine Elliott: Thank you.

Dr. Bernard Leduc: Craig? Any—

Mr. Craig Ivany: Absolutely.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

Mr. Craig Ivany: Thank you. Merci beaucoup.

CANADIAN RED CROSS

The Chair (Mr. Ernie Hardeman): We have the Canadian Red Cross. Colette Lavioire? Thank you very much for joining us this afternoon and presenting some points to help us in our deliberations in the review of the LHINs. As with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's any time left, we'll have some questions from our committee. With that, the next 15 minutes are yours.

Ms. Colette Lavioire: Thank you. First of all, I'm here to represent Lori Holloway, our national director of health. Just so you know, I'm taking her place today.

My name is Colette Lavioire. I'm with the Canadian Red Cross at the Cornwall branch, and I am the manager of community support services. Thank you very much for the invitation. It is greatly appreciated by the Canadian Red Cross.

I do not have a PowerPoint presentation, but I did give out the presentation that I will be going through in the next few minutes. If anyone has any questions in French, I am definitely able to answer your questions, just to let you know.

About the Canadian Red Cross: Our mission at the Canadian Red Cross is to improve the lives of vulnerable people by mobilizing the power of humanity in Canada and around the world. The vision of the Canadian Red Cross is as the leading humanitarian organization through which people voluntarily demonstrate their caring for others in need.

The Canadian Red Cross Society is part of the largest humanitarian network in the world, the International Red Cross and Red Crescent Movement. This network includes the International Committee of the Red Cross, which we refer to as the ICRC, the International Federation of Red Cross and Red Crescent Societies, and 187 national Red Cross and Red Crescent Societies dedicated to improving the situation of the most vulnerable throughout the world. Throughout the world and here in Canada, the Red Cross is known for its leadership role, mostly in disaster management and both emergency and community-based health care.

Our commitment to community-based health care in Ontario: The Canadian Red Cross has recognized the necessary and critical leadership role it must play in improving the health and well-being of Ontarians. Whether it's ensuring a meal is delivered to an isolated senior, access to transportation is available to attend medical appointments, personal care is provided to a physically disabled adult, or a senior is cared for in their home, the Canadian Red Cross has been working on a daily basis to address health and psychosocial needs in our communities.

The commitment of the Canadian Red Cross to community health care is clearly articulated in our strategic plan: People will have improved health status through community-based actions by enabling the elderly, the ill or injured to live more safely and independently.

As we build on this foundation toward a vision and strategy that will take us to 2020, we recognize and will embrace new models of health and wellness programming that will address, in a holistic and resilience-based approach, the needs of Canada's most vulnerable individuals. With the solid foundation of our home care and community support programs, we will continue to work collaboratively with government and community partners to build local and community resilience to vulnerability through client-centred, integrated and cost-effective community-based health care.

There is a growing recognition of the role that home and community support services can play and will play in the health and wellness of Canadians. The transition of health care to the home and community is a wise one being undertaken by the government of Ontario as part of Ontario's Action Plan for Health Care. In fact, we believe that the community sector can be utilized to an even greater extent to ensure greater access to quality health

care in the home and the community; more integrated and seamless access to a full basket of services that not only keep people aging within their own homes but also allow focus on the social determinants of health, such as social interaction, which ultimately improves health, wellness and quality of life; and more cost-effective solutions to manage low-acuity patient needs while decreasing the strain on long-term care and hospitals and ensuring adequate resources for high-acuity and complex patient needs.

Our budget recommendations: Keeping people living independently in the community and out of hospital is a more cost-effective means of health delivery than institutionalized care. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms while also decreasing long-term-care placements and long-stay hospitalizations, all at a lower cost to the health care system.

We applaud the government for past investments in the sector but have several recommendations for more targeted investments in the coming year.

Our first recommendation: Recruiting and retaining workers is made difficult by the disparity in compensation and working conditions between the community health sector and the institutional health sector. We must ensure, to meet current and future demand for home and community support services, that there is sufficient funding flexibility afforded to sector agencies to attract and retain qualified personal support workers. We recommend a commitment that would allow for immediate wage increases for home care and community support service personal support workers, which are greatly needed to stabilize the workforce.

Our second recommendation: Even with designated increases for the community sector in the last two Ontario budgets, home and community care agencies are still behind on maintaining the necessary infrastructure, as budgets have been frozen for several years and funding increases have been targeted to increasing service volumes only. Zero-based budgeting is destabilizing the sector. We will be unable to keep up with the demands of more service at home if this is not addressed.

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Acknowledging and addressing this reality is a key determinant in ensuring the effective delivery of quality results that the government and public rightly seek. We recommend that, moving forward, infrastructure costs and cost of living be recognized as a true cost of operations of community support services.

Our third recommendation: Ontario and Canada are experiencing more natural disasters and emergencies, yet we lack the proper protocols in place to ensure the most vulnerable people can be supported during an emergency. The Canadian Red Cross is part of an innovative program in the Sault Ste. Marie area called the vulnerable persons registry that has won international awards for its innovation. So we recommend that the Ontario government invest in an expansion of the vulnerable persons registry, which, through a community-based, volunteer-driven

model, could provide daily supports for independent living, plus act as an incredible resource in times of emergencies to ensure that first responders find and support the most vulnerable people in our communities first.

Thank you again for the opportunity to provide input into the Ontario pre-budget consultations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It does sit somewhat together with what we're doing here, but it's not the pre-budget consultations.

Ms. Colette Lavictoire: Okay.

The Chair (Mr. Ernie Hardeman): But we do appreciate it. We have six minutes, two per party, and I think we start with the government side. Mr. Fraser?

Mr. John Fraser: Thank you very much for your presentation. I'd like to go back just to your last point, where you were talking about the vulnerable persons registry. Could you just give us a description of how that is held together and how that came to be?

Ms. Colette Lavictoire: Yes. I don't have all the details, but there was definitely a need in that particular geographic area to address the frequency—as you know, there were a lot of natural disasters and emergencies. This is how, I think, the community and the providers in that particular area figured that this would be a very good program. Certainly, I can find out more details about it, but this was a way to address those issues in that area.

Mr. John Fraser: So that was something that was built out, and the Canadian Red Cross was part of that community coalition that did that?

Ms. Colette Lavictoire: Yes, exactly, and working very closely with the LHIN in that area, and other community partners.

Mr. John Fraser: Okay. So it was an initiative very similar to a lot of initiatives that we've heard about over the course of the hearings.

Ms. Colette Lavictoire: That's correct.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. I'm wondering if you could tell us a little bit more about the interaction that the Canadian Red Cross has with the local LHIN, and the projects that you're working on.

Ms. Colette Lavictoire: Yes, definitely. If I use the Cornwall branch, for example, we currently have a very good partnership with the Champlain LHIN. We do provide several services in this area, such as supportive housing, assisted living for high-risk seniors, transportation, attendant care and also aging at home. Actually, our interaction with the LHIN—we have a very positive working relationship with our Champlain LHIN. At any time when it had been identified that there was a need to expand certain services, all the information was shared with the LHIN, actually working in consultation with them. They've been very supportive, when we have identified that there was a need of a certain client in the community, to expand certain services.

Actually, the most recent program was the assisted living for high-risk seniors, which again was to decrease the number of ER visits and address the ALC. So, actually, this has been a very great program for our seniors.

Mrs. Christine Elliott: Terrific. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Gélinas?

M^{me} France Gélinas: Through the work that you do, do you also have contracts with the community care access centre?

Ms. Colette Lavictoire: We work in partnership with the community care access centre. Actually, the community care access centre will make referrals to the various programs that we have that are directly funded by the Champlain LHIN. For example, attendant care: If the community access centre does identify a need to refer a client that would need assistance with their personal care activities of daily living, in a lot of cases, they are the referral source. For our assisted living for high-risk seniors program, the CCAC is the main referral source. They maintain the wait-list and, because we're funded right now for 60 units in our area, the CCAC will refer the clients if we have a discharge and have some space within the program.

M^{me} France Gélinas: Do you have any home care PSW services?

Ms. Colette Lavictoire: All our personal support workers are working directly for the Canadian Red Cross, but they have their personal support workers. So, actually, it would be the equivalent of some of the personal support programs that exist through the CCAC, but we are servicing the clients as part of our community support services. It's not meeting sometimes the mandate of the CCAC, so they will make the referral for our programs.

M^{me} France Gélinas: Do most of your programs have a cost to the clients who use them?

Ms. Colette Lavictoire: There's no cost to the client except for the transportation program. There is a cost to provide the transportation, because this is volunteer-based, so we have a group of volunteer drivers taking clients to their out-of-town medical appointments, but sometimes if someone cannot maybe afford the full amount, we get some type of subsidy. In our case, it's with our United Way funding to assist these clients who need to get to their medical appointments and, unfortunately, sometimes cannot afford to pay the full price.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate it.

Ms. Colette Lavictoire: Thank you.

ROYAL OTTAWA HEALTH CARE GROUP

The Chair (Mr. Ernie Hardeman): Our next presenter is the Royal Ottawa Health Care Group. Nicole Loreto is here to present—the vice-president of the group. Welcome, and thank you very much for taking time to come and talk to us this afternoon. As with other presenters, you will have 15 minutes to make your

presentation. You can use any or all of that time for your presentation. If there's any time left, we'll have questions from our committee. With that, the next 15 minutes are yours.

Ms. Nicole Loreto: Perfect. Great. Thank you very much. Bonjour, tout le monde. I just brought a presentation in English, but I'm willing to answer any questions in French—M^{me} Gélinas, en particulier. I totally didn't get a chance to bring one.

I'm here on behalf of my boss, George Weber, who was unable to attend. We thought this was a good opportunity to give our perspective from the Royal. As you see in the presentation, we're one of the 24 academic health science centres of Ontario, and one out of two that specialize in mental health. There's ourselves and CAMH in Toronto.

I thought I'd spend a couple of minutes just giving a really quick overview because we operate an Ottawa campus and a Brockville campus, and we have a range of programs. In Ottawa, the main service is with the Ottawa mental health centre. This is where we have 190 beds. Specifically, of 96 that are attached to the mental health centre, we have 32 recovery beds—and I can get into that if people have questions, because that's something seen more as a step-down program as people leave from an in-patient unit back to the community—and then 64 long-term-care beds, and that's something that we're involved in.

In Brockville, the services are specifically in terms of those that we offer for the not-criminally-responsible. We run a large unit there, which is 161 beds. We have 100 beds which is the STU, which is another ministry, not the Ministry of Health but the Ministry of Community Safety and Correctional Services. Also, we oversee 183 beds of special homes out in the community, where residents who have been an in-patient have now moved into the community.

The next two pages are basically who we serve. We're a tertiary care centre, obviously for people living with serious and persistent mental illness. The list is quite detailed there.

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We also serve primary care physicians through a service that we have called consultative services, and shared care, just because with mental health, you have the primary health care centres. The hospitals have their emergencies where they get serviced, and then if there's persistent need, let's say beyond the two weeks, then they would come to the Royal for specialized care. In terms of our role as an academic health science centre, we also provide all the training for the future psychiatrists, psychologists, social workers, nurses and recreational therapists for eastern Ontario. As part of the Royal, too, on one of the slides you'll see that we also have the Institute of Mental Health Research. That's part of our mandate in terms of looking at specialized research in mental health. We're quite excited because obviously there are some new developments, and we want to actually work

towards finding better solutions to help people with mental illness.

On one side you have the list of all our programs, everything from anxiety disorders to youth programs. We also run a women's mental health centre, a sleep disorders clinic and, in particular, the Ottawa Operational Stress Injury Clinic. We got funding from Veterans Affairs to run a specialized clinic for post-traumatic stress disorder for the military. One of the key programs that is known, I think, in the province is the geriatric; it's one of those models where we provide intense care, but we actually have a rotating team that goes to all the long-term-care facilities to assess the needs of people in residential care.

Obviously, I know my time is going quickly, so the next two pages are the list of people we serve. It goes over 26,000 from admissions, in-patient to outpatient, and students. We also have the number of staff listed on those two pages.

We wanted to take this opportunity to cover a couple of points. The Royal, as a member of the OHA, believes in the principles of a high-performing health centre, the nine principles that they've outlined. We're going to comment today in particular on one, which is the interconnectedness of services.

We have just a couple of points to make in terms of the LHIN. For us, the Champlain LHIN has been very supportive of our work and understanding the needs of the region. This has evolved over time, I think in the last couple of years in particular. We've had to undergo significant restructuring with the 1997 directive. That was important particularly in Ottawa and in Brockville. There was a lot of support there and a genuine willingness, I think, from the CEO to the staff, in terms of understanding our business because we offer so many programs right across the region, everything from geriatrics to youth. Even our youth program is something that we share; we work with CHEO specifically to make sure to minimize any of the gaps in service delivery for youth. That's something that's quite complex, and there has been a genuine willingness to understand our operations to the point where even the CEO has attended our board retreats with our board of trustees, and also a member of their staff when we do our strategic planning. We think it's important, especially when we look at the continuum of care.

One of the points I wanted to highlight, as an example of the relationship, is our new Regional Opioid Intervention Service. This is something that we're particularly proud of and is also something that we aspire to in the future in terms of a model. We had two physicians actually develop the idea of having an opioid intervention service for those 30 years old and under, so to try to do some early intervention. That's been quite successful; we've now celebrated just over a year. Why the LHIN has been particularly supportive of that is, we've kind of presented a hub-and-spoke model where a lot of the intense services and assessments are delivered at the Royal but in partnership with all the community partners

because relapse is such a critical issue for people, and we wanted to make sure we had that type of model. They've been very, very supportive, and it now has actually become a main program. We have to say that we were actually honoured to also win—our two physicians won the innovation award from the ministry earlier on, at the end of November. That was one example and we think it's a good model for the future.

In terms of other points, we believe that the Champlain LHIN should have a broader mandate, or at least a mechanism to influence and coordinate the funding. When you're running a mental health centre and you have funding from different parts within one provincial government, it's very difficult. Children and youth is on one hand, then the Ministry of Health and Long-Term Care, and then within the Ministry of Health and Long-Term Care there's a forensic component if they're not criminally responsible, and then there's also the whole correctional services and community safety.

In terms of the coordination for funding, especially because often you'll see some of the members of the public in some of those programs—not all—we think that there might be some benefit in having the LHIN have greater influence and some kind of mechanism for that, particularly when you look from prevention to intervention at all the levels.

For us, it has to be one system trying to follow the patient, also depending on where they are. We see that often in children and youth, where they might be in the system, they might have come from CHEO, they're in the Royal, and then after that the adult system happens. There are gaps in there, and there's also trying to coordinate the services so that you can actually support the clients throughout, because mental illness is a chronic disease and we need to structure it that way.

Another two points: We think the Champlain LHIN—and other LHINs, obviously—should have oversight on public health, primary care and ambulance services. Public health—because I think you've heard other speakers talk about social determinants of health—again, it's a patchy system. You have some services overseen by the city, in terms of housing. We have clients with special needs, not only dual diagnoses, but also developmental needs and mental illness in the community, and then trying to have those types of services. Then we also do all kinds of psychiatric; we have a psychiatric outpatient team that actually does assessments for those currently not in the mental health system. They're actually in the shelters or on the streets, so it's trying to look at those services.

In primary care, one of the reasons why we've had to change part of our system is because right now the waitlists are very high, and sometimes it's trying to see if it's more for providing consultative services to physicians who want to maintain and try to help some clients, or if they require specialized care. So that still has to be figured out.

I think we're evolving quite nicely in terms of the system and the feedback we're getting from primary care,

but there has to be better connection. I think, from that perspective, the LHIN can certainly help from a capacity-building side.

Ambulance services, as well—we've highlighted it there just because it's the feeder system, because they're the first ones that actually have to deal with some of the patients. Right now, sometimes if they don't get to hospital they might be elsewhere, and we have to find a way to make sure that all the services are coordinated. For us, that is pretty key.

Now, obviously the big question is in terms of reviewing the role, and there have been all kinds of suggestions. We find that there are lots of changes currently in the mental health system, but also just in the health care sector, and we fundamentally believe that, instead of trying to change something, we need to build on what we have, because I think there's a lot of opportunity for the future in terms of making sure that we provide one system of care. From our perspective, we believe in trying to enhance what we currently have as the way to go.

I've gone really quickly, but I'd love the opportunity to answer any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, and we do have some time for questioning, but only one caucus, so we'll start with the government caucus. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much. Thank you for coming. Can you describe for us exactly how you do currently interact with the LHIN? What sort of committees? How does it work between the Royal Ottawa and the LHIN now?

Ms. Nicole Loreto: Currently, I think, with the LHIN there are all kinds of different committees on needs. There's obviously the mental health and addictions committee. We're involved at specific levels, also the ALCs between all the hospitals. We try as much as possible to work within the hospital sector, so anything that's required from the LHIN—I think even one current project that we're going to start is to look at some of the capacity needs in the system.

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Ms. Helena Jaczek: And you weren't sort of interacting with the acute care sector so much before? Can you say the LHIN has really made a substantial difference? Do you see progress?

Ms. Nicole Loreto: I think we're seeing progress in the sense that now there's a greater perspective in terms of the regional needs, and I think that has been an evolution. We interact with the acute sector on a daily basis almost, just because often the patients, if they're not able to stabilize in the hospital, will be referred to the Royal. Right now, the only way you come into the Royal is either through one of the hospitals or referral through physicians specifically. There's only one program, which is our concurrent Meadow Creek, where we do detox—that's the only self-referral where someone can actually come and ask for service. The rest is really through the current hospital system.

Ms. Helena Jaczek: But your current patients, presumably, come from much more than just the Champlain LHIN, being one of two in the province, pretty much, academic health science centres—

Ms. Nicole Loreto: Most of our patients are from the region, and we have a breakdown we can actually circulate. We've done an assessment in terms of looking at where we service and what the actual rates are to be able to project for the future to understand that better. But it's mostly residents; the only one where we'll get people from outside the region is because of our detox centre. We have a level 4, and we'll accept people, let's say, with a certain level of addiction who would not be accepted elsewhere, in particular Toronto. They actually come to the Royal. The OSI is for the military. We service all of eastern Ontario and the western part of Quebec and Nunavut. We do some consultation services up north, but generally the population is in the region.

Ms. Helena Jaczek: Do I have more time?

The Chair (Mr. Ernie Hardeman): Yes, for a very quick one.

Ms. Helena Jaczek: And what current contact do you have with the public health units?

Ms. Nicole Loreto: Again, a lot of individual physicians, just because of some of the work that they're doing in the shelters, so there's a lot of existing coordination. We're also trying to bring in some new tools, common tools, in terms of assessing needs and requirements in terms of where we could best serve the patients. But that would be generally—it's our physicians on a day-to-day basis, depending on the client. Particularly our community ACT teams, because they're out in the community, will interface a lot with public health.

The Chair (Mr. Ernie Hardeman): Thank you very much for the questions, and thank you very much for your presentation. It's much appreciated.

Ms. Nicole Loreto: Thank you very much.

CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM

The Chair (Mr. Ernie Hardeman): Our next presenter is Marie-Josée Trépanier from the Champlain Maternal Newborn Regional Program. Thank you very much for coming in. As you're getting set up, we'll set the ground rules for your presentation. You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left over, we'll have questions from the committee. Your time won't start until you put the first picture on the screen.

Ms. Marie-Josée Trépanier: Okay.

The Chair (Mr. Ernie Hardeman): I usually say, "It starts now," but I didn't want to do that. That's not fair.

Ms. Marie-Josée Trépanier: I don't mind starting.

The Chair (Mr. Ernie Hardeman): Okay, very good. The next 15 minutes are yours to use any way you see fit. The clock is starting to tick.

Ms. Marie-Josée Trépanier: Okay. Bonjour. Merci de m'accueillir. Mon nom est Marie-Josée Trépanier. I'm from the Champlain Maternal Newborn Regional Program, going from mental health to care of moms and babies in our region. I'm pleased to be here to just give you an overview of our program and what we're up to and what we've been achieving over the past few years.

Our program has actually been in existence as a regional maternal newborn integrated program since the early 1980s by a visionary called Patricia Niday, who thought about and knew about the vision of having the planning for moms and babies at the regional level. Since the creation of the LHINs, we became more official under the Champlain LHIN.

You have my presentation. Hopefully, the writing is large enough.

Historically, since the early 1980s, we've actually worked very closely with the South East as well, so that's why we're including the South East and the Champlain. Although our name is Champlain Maternal Newborn Regional Program, we do work very closely with the South East.

Our name changed over the years. In 2010, we became the Champlain Maternal Newborn Regional Program when it became incorporated within the Champlain LHIN officially, with the integration decision.

Who we work with is the tertiary care hospitals in Ottawa—CHEO and TOH—as well as Kingston General Hospital; the large community hospitals; the eight small community hospitals in both Champlain and South East; the six regional public health units; the 11 midwifery practices; the 12 primary care community health centres; the two universities; and various other community agencies that have anything to do with the care of mothers and babies during pregnancy, during birth, and after, in the postpartum.

Interjection.

Ms. Marie-Josée Trépanier: Oh, is it there? Sorry, I'm just going to take a second here.

The goal of our program is, obviously, to improve maternal newborn care through the integration of patient-focused planning at the regional level. This is to improve the health of moms and babies. This is the start of life; this is the start of health. We truly believe in the importance of setting the stage for newborns, through the health of their mother and their family.

We want to improve appropriate, timely access to standardized and high-quality care and promote more effective, efficient management and coordination of services. This is done through everyone working together.

Did you find it?

Interjection.

Ms. Marie-Josée Trépanier: Sorry for the interruption.

We also work very closely with the universities. We want to establish a strong academic health program to be a major resource for education, learning and research, and work closely with the heads of the departments of obstetrics and gynecology and of pediatrics.

Interjection.

Ms. Marie-Josée Trépanier: Is it possible that it's not advancing yet? Okay, it's stuck here. Well, we can keep going with this.

We want to become a program of excellence to compete in the global market, to address an anticipated shortage of trained professionals, and we want to have exceptional people who can be recruited and retained within our program of excellence. We're actually quite unique in the province of Ontario as an integrated regional program, and we're often cited as an exemplar program in a community of practice networks.

I'm just going to go ahead here. Over the years, when we became CMNRP, there was a large group, hundreds of professionals, who got together over many, many months to create A Blueprint for Healthy Mothers, Healthy Babies, Healthy Future, and became the CMNRP that we know now. That was published in November 2009. A copy of that would be on the Champlain LHIN's website as well as our website.

In September 2010, the Champlain LHIN announced the appointment of our program's leadership team, with myself as regional director. I'm replacing someone who was in that role previously. Our medical lead for obstetrics and gynecology is currently Dr. Mark Walker, and the medical lead for newborn care is Dr. Thierry Lacaze. They're from the Ottawa Hospital as well as CHEO.

1520

Our program hosts a secretariat, and it's managed administratively within CHEO's infrastructure with, other than myself, five perinatal nursing consultants, both in Kingston and in Ottawa. We also now have neonatal nurse practitioners who provide services in the level 2 and level 3 neonatal units in our region, one project manager who is working on a capital project at the moment, and administrative assistants.

The next slide is going to be very busy, so I apologize. I'd be happy to forward you the full version. I meant to bring copies of that.

Just to see how we work very closely with the LHIN, you can see here in the middle that the leadership team works under the network, which works as a council, which is right under the Champlain LHIN. Some of the maternal newborn health service providers are funders, and the maternal newborn partners are all the health care professionals who provide services to mothers and newborns in the region. We have the program staff. We have developed quite a strong, solid structure of committees that ensures full participation of health care providers across our region, working on the various projects that we have going. We have a steering committee, but I'll come back to that. We have joint capital planning, which is looking at planning of infrastructure for care of mothers and newborns in our region. We have quality and performance management, which looks at data, monitoring that so we can improve care and services; interprofessional education and research; and a family advisory committee that provides advice on all the plan-

ning that goes on. The chairs of those committees make up a steering committee that reports back to the network. And we have various subcommittees: breastfeeding, research, joint orientation, education strategies etc. As you can see, there are a lot of committees and subcommittees, but it's all about working together with inter-professional groups.

I'll just go through many of the ongoing activities of our program, from conferences to workshops, courses at the university and Algonquin, and skills days.

We have telehealth sessions across the province, and those are through OTN.

We do annual visits to our partner hospitals. Just so you understand, we, as a leadership team, visit every hospital in our region to talk to them about how they're doing, their data, their key performance indicators, and provide advice and training as required. We do this every year. We provide consultation, design policies, procedures and guidelines, and we publish a newsletter, as well as communicate to keep all of our partners in line with what we're doing.

These are our three neonatal nurse practitioners providing care to very sick and unstable newborns in our level 2 and level 3 neonatal units.

Just a very quick overview of our main accomplishments: This year we have created our very first regional report, which is unique, again, to our region of Champlain and the southeast, around key performance indicators for our partners, and we share that with them so they can see how they measure up against similar hospitals in the province.

We have undertaken a very specific initiative around Caesarean section rates and have achieved a reduction. We're one of the only regions in the province where we've seen a significant reduction in Caesarean section rates in a particular population.

We're looking at tracking and monitoring a newborn-bed availability tool to help us have babies born at the right place at the right time and moved between units so that we're ensuring effectiveness—benchmarking as well, and some other guidelines that we've been working on.

We've also been working on research from a regional perspective. Breastfeeding is going to be very high on the ministry's radar, coming up. There are some big initiatives coming down from the provincial level that we are very much in line with.

The family advisory committee is very active in looking at everything else we're doing at the regional level and giving us their input. That's a large committee of about 20, and half of those are actually family advisers and looking at our initiatives.

The joint capital planning committee has been active since the blueprint was published a few years ago in looking at amalgamating some of our hospital maternal newborn care from five sites currently in Ottawa into three. You can imagine the significance of working together, those five organizations, and planning together to ensure that a new maternal newborn centre is built

down the road in a few years, but making sure that all the master plans occur at the same time or are lined up so that we can maximize the effectiveness of maternal newborn services in our region.

We've worked together for a few years now. What we want to do is build a state-of-the-art tertiary care centre that integrates obstetrical and neonatal programs. Right now, they're divided up between three sites in Ottawa. We believe that bringing them all together will enhance the effectiveness of the care and the planning.

The last little bit I'll tell you about: The most recent announcement in Ottawa is the building of a stand-alone midwifery-led birth centre. CMNRP was involved in the application process as well as the development, working closely with our midwifery groups. We were successful in being designated as one of the two pilot sites in Ontario. We're pleased that it actually opened last week, and the first baby was born on the weekend. We're excited about this project and the fact that CMNRP was able to work closely with our partners to make it a successful initiative.

Is there time for questions?

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have just over a minute, and it goes to the opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. My question just relates to the role that the LHINs have played in the development of your program, since you have been around since the 1980s. Can you tell us what the difference has been since the LHINs were implemented several years ago?

Ms. Marie-Josée Trépanier: Since the LHIN—the program didn't have that structure at the regional level, although it was kind of an understanding that we would all work together. But now it's much more formal, and we do have LHIN representation at the network level as well as some of our committees. At the quality performance committee, we have a LHIN representative, as well as at joint capital planning.

The Champlain LHIN CEO works very closely with the other CEOs, especially around the capital planning, and was instrumental in recruiting our medical leads. They're providing funding for the medical leads as well as for the new neonatal nurse practitioners that we have on board now. So their support has been instrumental.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time. We thank you very much for coming out and making the presentation.

Ms. Marie-Josée Trépanier: You're welcome.

The Chair (Mr. Ernie Hardeman): With that, I believe that concludes all the delegations that came today. We thank, first of all, all the presenters, and we thank the committee for your indulgence. We hope that with your visit during the lunch hour to other attractions in the village, you didn't have to suffer much this afternoon to get through the meeting.

With that, the committee stands adjourned, to meet again tomorrow morning at 9 o'clock in the city of Kingston. We stand adjourned.

The committee adjourned at 1529.

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ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40^e législature

Official Report of Debates (Hansard)

Tuesday 11 February 2014

Journal des débats (Hansard)

Mardi 11 février 2014

Standing Committee on Social Policy

Local Health System
Integration Act review



Comité permanent de la politique sociale

Étude de la Loi sur
l'intégration du système
de santé local

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 11 February 2014

Mardi 11 février 2014

The committee met at 0902 at the Holiday Inn Kingston Waterfront Hotel, Kingston.

LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the committee of social policy to order and say good morning to the committee and to our audience. It's great to be here in Kingston to continue our public consultation on the review of the Local Health System Integration Act, and the regulations made under it, as provided for in section 39 of the act. We've been travelling all around the province. This is the eighth day and the ninth city, or should I say the eighth city and a smaller town? But we're very happy to be here.

SOUTH EAST COMMUNITY CARE
ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our first presentation this morning is the South East Community Care Access Centre: David Vigar, chair of the board, and Joanne Billing, senior director, client services. Are they here? If you would come to the front table here. Thank you very much for taking the time to come talk to us this morning. As you're sitting down to get comfortable, you will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If there's time left, we'll have some questions from the committee, but from now until 15 minutes from now—all that time is yours to use as you see fit. Thank you very much for being here.

Mr. David Vigar: Thank you very much, Mr. Chair. My name is Dave Vigar. I'm the chair of the board of the South East Community Care Access Centre. Before retirement, I worked for over 20 years as a CEO in the health care system in Ontario and Manitoba, most recently leading the amalgamation of three hospitals in Lambton county and prior to that the formation of a new hospital entity in the Cobourg-Port Hope area. I was also a surveyor for Accreditation Canada for 12 years and have conducted accreditation reviews across Canada, in South America and in the Middle East.

With me is Joanne Billing, the clinical lead for South East CCAC client services. Joanne has worked in health care in the Kingston area for over 25 years. She has been

involved with both the administrative and clinical operations of home care and has participated in numerous initiatives associated with the transformation of the health care system.

In our presentation today we'd like to talk to you about how our work with our LHIN and our health care partners is improving care to our patients and the community. We'll share some suggestions for improving LHSIA and the local delivery of health care services.

We believe that the Local Health System Integration Act works well overall and sets out a strong framework for local health system planning, funding and accountability. Our suggestions are intended to strengthen the current framework.

First, a little bit about the South East: A variety of population-specific characteristics in the South East have an impact on the provision of care in the community. The South East has the highest proportion of population aged 65 and older in Ontario: 16.7%, compared to the provincial average of 12.9%. Residents of the South East have higher-than-usual prevalence of diseases such as arthritis, rheumatism, asthma, diabetes and chronic bronchitis, and the highest prevalence of heart diseases in the province. The burden of illness is so significant that it results in a life expectancy approximately 1.8 years lower than the Canadian average.

I'd now like to ask Joanne to provide you with some additional information about the South East CCAC.

Ms. Joanne Billing: Thank you, David. As an accredited organization, the South East CCAC coordinates care for more than 12,500 individuals on any given day. Last year, we provided over one million hours of personal support—more than 100,000 more personal support hours than the year before—and we helped 3,451 children attend school.

Care coordination is our core service; not administration. It is patient care, and it is essential. Our care coordinators are all health care professionals and are mostly nurses. They work directly with our patients, their families and other health care providers to identify each person's individual needs, develop care plans, and ensure that people get the right care at the right time and in the right place to meet their needs.

Our care coordinators work in seven hospitals and all of the emergency departments across the South East. They work with family physicians, schools, every community agency and every long-term-care home. This

network of care coordinators helps to ensure consistent care and practices across the South East and the province, and that must be done to support the many families who rely on our help.

I will share an example of how our care coordination helps people receive the right care at the right time and in the right place. Ivy Bennett struggled with living in a secure unit in a long-term-care home. She ended up there after she was brought to the hospital with an infection and the antibiotics she was given were not working. The infection was causing Ivy's already-compromised memory to decline. She became confused and started to wander, which caused concerns with respect to her safety. She was deemed unable to return home safely. As a result, she was placed, as a crisis, in a long-term-care home. That home was not close to her family. After falling in the long-term-care home, Ivy's granddaughter Lorraine wanted to bring her closer to home. Lorraine worked with the South East CCAC to relocate Ivy to a nearby long-term-care home, and ultimately to return to living at home, in the community. With a focus on providing the right care in the right place at the right time, the CCAC care coordinator worked with the family to develop an individualized plan and provided system navigation to help the family access home care services such as personal support and occupational therapy, as well as services such as an adult day program one day a week.

Ivy is happy to be back at home. In the words of the family caregiver, "The government is on the right track trying to keep people at home as long as possible. It delivers good value and enhances the family experience. The care in the long-term-care home was good, but the support of the CCAC has helped us to feel empowered, and Nana is much happier at home."

We think the LHIN is on the right track in the South East too. The South East LHIN has led a number of initiatives that have improved the efficiencies and effectiveness of the local health system to meet local needs. Increased access to information empowers patients and their families to learn about health and their health care options. Technology is a critical enabler of high-quality care and cost efficiencies. An example of this lies in the introduction of the integrated community assessment and referral team, or iCART, which is an important part of the South East LHIN's Clinical Services Roadmap initiative and aligns with Ontario's Action Plan for Health Care in providing the right care at the right time and in the right place.

0910

The iCART team is made up of hospital staff, CCAC care coordinators and community support service workers. They share their assessments of high-risk patients to ensure they develop a coordinated care plan. The objective is to avoid duplication of services, reduce delays in receiving services and minimize client and caregiver confusion. A vitally important part of the plan will also be to make sure the client is visited often enough at home to diminish their anxiety, prevent social isolation and

avoid their seeking help through the emergency room for non-acute needs.

The South East LHIN has a goal of using technology as an enabler for improved care outcomes for patients. Over the past year, the LHIN has supported the CCAC's adoption of an electronic notification system which alerts CCAC care coordinators to the presentation of one of their patients in a hospital emergency department. By alerting CCAC care coordinators that one of their clients has gone to an emergency department for treatment, the care coordinator can intervene to get the patient back home safely and efficiently.

By connecting patients back to their care coordinator as efficiently as possible, we are ensuring that more people are receiving less costly care at home, where they want to be. This leads to improved health outcomes and makes efficient use of health system resources.

Another focus for the South East LHIN has been reducing alternate-level-of-care rates across the South East. A noticeable reduction in alternate level of care reflects how patients in the South East are transitioning towards community-based services faster. Repeat visits within 30 days and readmissions have also been maintained within targets, revealing that the care being provided to the patient has been effective in keeping the patient from returning to hospital.

In the past year, the development and expansion of health links has been fully embraced across the South East LHIN, where there is a specific focus on the 5% of Ontarians who account for 66% of health care spending. Working more closely with primary care through health links, we, as a system, can provide increased focus on innovative, coordinated care delivery for the most complex patients.

Health links across the South East have already started to encourage greater collaboration between existing local health care providers, including family physicians, nurse practitioners, specialists, hospitals, long-term care and other community supports.

Health links put family care providers at the centre of the health care system. By bringing local health care providers together as a team, health links will help family doctors to connect patients more quickly with specialists, home care services and other community supports, including mental health services.

In order to establish a health link, strong representation from local primary care providers and the CCAC is required. Working closely with the South East LHIN primary care lead, the South East CCAC has actively been involved in the development of the seven health links in the South East LHIN.

To conclude our presentation today, David will share our recommendations to strengthen LHSIA.

Mr. David Vigar: Our population expects the health care system to be integrated, well coordinated and easy to navigate. Working with our LHIN, we are making important changes to improve the care that people receive, but we know that there is more to be done. Our population is aging, and our health care system is in the midst of

a significant transformation to prepare for the future needs of our communities. We believe that LHINs and LHSIA provide the right foundation to support this transformation.

We believe the following three recommendations will strengthen LHSIA and provide better health integration to the communities we serve.

The first recommendation is that public health and primary care should be brought under LHSIA to ensure we deliver seamless, coordinated care across the continuum, including health promotion and prevention. Clearly, the inclusion of primary care in the LHIN mandate is a key to the complete and effective integration of health services and the resulting quality and effectiveness of the patient experience.

Our second recommendation relates to how services are funded. Opportunities exist within the system to improve funding processes. It is difficult to plan how to best meet the needs of those we provide care for when funding announcements are fragmented over the course of the fiscal year. It would be beneficial to know our operating budget prior to the beginning of our operating year. Additionally, multi-year funding would allow us to plan and build out the system with more confidence.

Our third recommendation is that, beyond expanding the LHIN mandate to include primary care and public health, any conversation regarding possible structural changes has to take into account the disruptive effects of those changes. CCACs underwent a major structural change eight years ago to create the alignment with LHIN boundaries. While it was the right thing to do, we know, based on our experience about the time lost, the cost to the taxpayer and the uncertainty within the health care system which accompanies major system change.

The energy required to make this level of change takes focus away from efforts to bring real improvements to the services that Ontarians require. Before change based on random anecdotal events is undertaken, it is essential to ensure that the outcome is worth the cost and disruption.

In summary, we believe that the Local Health System Integration Act works well overall and sets out a strong framework for local health system planning, funding and accountability. The system changes that were made eight years ago are beginning to bear fruit, but can be improved.

To recap, we have three recommendations:

(1) We recommend that public health and primary care be brought under LHSIA;

(2) LHINs should provide multi-year funding; and

(3) While modifications to LHSIA can provide more integrated and stable health care, we must ensure that any changes are not disruptive to the communities who we serve by working within existing structures.

Only in this way can we deliver a health system our communities can rely on that is integrated, well-coordinated and easy to navigate.

Thank you for the opportunity to speak with you today, and we would be pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about a minute and a half. It'll be the government caucus: Ms. Jaczek.

Ms. Helena Jaczek: Thank you for coming. Thank you for yet again trying to explain the role of the care coordinator, and acknowledging that people look at it as administration. I think those of us who were on the Select Committee on Mental Health and Addictions certainly heard during that process that system navigation is a very important component, and care coordination seems to be part of that.

Now, many people coming out of hospital have very standard needs: You've got a wound, you've got a drain, you've got a joint that needs to be mobilized or you're frail. How have you streamlined your protocols to make sure that that care coordination is done in an efficient way?

Ms. Joanne Billing: Thank you for your question. One of the things that, as a sector, we've been working on is care pathways, outcome-based pathways that clearly articulate the expectations of our service provider and, indeed, what results a patient should anticipate receiving within a prescribed period of time. In order to effectively care for an individual in the most efficient possible way, we've introduced care pathways.

When you speak of wounds, for example, wound care in particular is a feature within the outcome-based pathway development that we have done as a sector, and indeed, we are introducing that across our LHIN and across the province.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time.

OASIS SENIOR SUPPORTIVE LIVING INC.

The Chair (Mr. Ernie Hardeman): Our next presenter is Oasis Senior Supportive Living Inc.: Christine McMillan, secretary of the board of directors, and Rodger James, director of the board. Good morning, and thank you very much for taking the time to come and talk to us this morning.

Mr. Rodger James: And good morning to you.

The Chair (Mr. Ernie Hardeman): As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end of the presentation, we will have questions or comments from our committee members. With that, starting now is your 15 minutes.

Mr. Rodger James: Thank you very much. My name is Rodger James. I'm an investment and insurance adviser here in Kingston. I was a previous PC candidate in the last provincial election—unsuccessfully, obviously—but I'm also on the board of the Oasis program. This is our secretary, Christine McMillan, and we also have two board members in the background.

0920

I want to make apologies on behalf of our president—chairman, actually. Dan Corbett was called away on business, so Christine and I are going to handle the questions that may arise out of this. There will be a handout afterwards. There was far too much detail to try and cover in my presentation, so I'm going to highlight what we feel is important and give some history and certainly the savings that are available to the government.

John Gerretsen, our existing MPP, is certainly well aware of it, and we have made a presentation to him. The current health minister, Deb Matthews, has been down, I believe, twice to visit the Oasis program, which is in operation right now.

I'll do a summary here, and then questions and the handout will be later.

We appreciate the opportunity to tell you about an innovative assisted-living program called Oasis in one location in Kingston. The statistics submitted to the South East LHIN show that Oasis is saving the government over half a million dollars in health-care-cost dollars each year, and that's just from 11 seniors who are currently eligible for long-term care. Imagine what the opportunity is as we age.

Oasis is a registered not-for-profit organization in partnership with Homestead Land Holdings Ltd., the owner of a 60-unit accessible apartment building located in the Bowling Green apartments in Kingston. Oasis is providing the lifestyle found in retirement homes, but at an affordable price, to 59 seniors ranging in age from 70 to 97.

Oasis was developed by seniors, members of the Frontenac-Kingston Council on Aging. It was developed for seniors and with seniors who are active members of and in the program.

Oasis is different from other assisted-living programs. First, Oasis is not based on the medical model but rather on community development, where the seniors who are members of Oasis are the decision-makers in deciding what they want and how their needs can best be met. The community development model ensures that members who are seniors have the dignity of making decisions about their own care. The ability to make decisions about their own care provides a meaning for their life.

Second, Oasis is in partnership with a private owner of an accessible apartment building, Homestead Land Holdings Ltd., the largest owner of apartment buildings in Ontario.

Third, capital start-up costs are negligible since Oasis does not need to build a special building or furnish it.

Fourth, operational and maintenance costs are low since Oasis members pay their own rent, and regular building maintenance and cleaning costs are part of the general expense by the owner.

Fifth, the seniors are active participants in the Oasis program. By paying a user fee of \$8 for a three-course dinner served in a dining room by our volunteers, they have ownership of the food served. There are activities

and social events each day, many initiated and resourced by members or our volunteers.

Homestead sees value in our concept of bringing retirement home amenities into their apartment buildings, where normal-occurring retirement communities have developed. There is always a waiting list for this building.

Funding is the issue. When we had short-term demonstration funding—from the United Way, serving Kingston, Frontenac, Lennox and Addington, and the city of Kingston's Healthy Community Fund—we issued a contract to the VON, greater Kingston, for the provision of on-site personal support workers while maintaining the community-development philosophy. When this funding was depleted, the VON, as a registered health care provider, agreed to submit a funding application for this program to the South East LHIN. Since 2009, the South East LHIN has provided an annual grant of \$130,000 to the VON for the Aging at Home Strategy.

As a recipient of this annual funding, the VON must operate within their own policy guidelines, which sometimes are inconsistent with the community-development philosophy of Oasis, where we do things with our members' consent. Health care providers do things for clients, not for members.

Oasis is a driving force behind this community-development model. The fact that the LHIN, under the current regulations, is unable to flow funds through not-for-profit organizations providing a comprehensive assisted-living program complicates, if not wholly negates, the opportunity for expansion of the Oasis concept.

Similarly, we are not eligible to apply for funding from the supportive-living allocation made by the South East CCAC, even though they were instrumental in the establishment of Oasis and in choosing the building.

At the same time, the opportunity to expand this cost-saving, quality-of-life option for older seniors appears to be limitless. Homestead has requested that Oasis expand to other buildings in the same complex, where there is a large population of older seniors. The board of the Pine Street seniors' apartments, a United Church program offering some rent-geared-to-income apartments, want to partner with Oasis, and a group in Toronto wants to initiate an Oasis program.

The administrative functions for this one Oasis site are performed by a volunteer board as well as site volunteers. We recognize that this is not a sustainable model. If we were to expand to other sites where there was a naturally occurring retirement community, called a NORC in research literature, employing a small administrative staff will be necessary to supplement the vital volunteer component. For this vibrant and innovative cost-saving program to expand, we are asking that a new regulation be developed that will allow a funding stream from a LHIN to a not-for-profit organization who is in partnership with an approved owner of an accessible building. In the formal presentation, which we are leaving with you, we have proposed an amendment as one suggestion that will

allow Oasis to expand, thereby setting a new standard for assisted living.

In closing, I want to share with you the motto that the Oasis members accepted as their own. It is taken from the report of the federal seniors' advisory committee: "Oasis: Adding years to life and life to years." Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about seven and a half minutes left. The questions will start with the PC Party.

Mr. Rob E. Milligan: Thank you very much for taking the time to come here today and present some, I find, quite intriguing facts.

I do have a couple of questions. How long has Oasis been functioning, up and operational?

Mr. Rodger James: Five years.

Mr. Rob E. Milligan: Five years. And what was the initial idea of forming Oasis to provide that service in the community?

Ms. Christine McMillan: I was working with the Council on Aging at the time—our local council. We had dealt with some seniors who were being abused in rental housing. We held 12 focus groups for seniors who were in rental housing to find out if there was any abuse going on by the management or the staff. What came out of every one of those was that seniors were fearful of dying alone in their apartment. Many didn't have families who lived in Kingston. But they couldn't afford to go into a retirement home. Their only option as they aged was to apply for long-term care. That is not a sensible option for competent older seniors.

We looked at the models of what was provided in retirement homes and thought we could do the same, but in a regular apartment building. It took some time for the board to come to terms with it because we knew this was going to be a huge project for a small organization. We were—Brian Brophy, who's here now—at a meeting where the Minister of Health at that time was present, and he announced 98 more long-term-care beds. I happened to be standing beside the executive director—CCAC at that time—and she said to me, "Isn't this wonderful? Ninety-eight more long-term-care beds." And I said, "I think it's terrible." She said, "Terrible?" And I said, "Yes; 60 of those 99 beds will be filled by seniors who don't want to be there." So that was the motivation.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^{me} France Gélinas: Thank you so much for coming, Ms. McMillan and Mr. James. Why is it that you have to go through VON and you cannot have a contract directly with your LHIN to provide the support?

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Ms. Christine McMillan: There is no regulation under the act that we could find. We thought we had found one, but then we found out that it didn't really apply. The only people the LHINs can fund are registered health care providers.

M^{me} France Gélinas: Given that you don't qualify as this, you can't. Why is it that you cannot get a contract with your CCAC, your community care access centre?

Ms. Christine McMillan: Because they're under the same terms of reference. We're innovative, so there is no funding for innovation that will allow the South East LHIN to even do it on a three-year basis and then evaluate it while a regulation might be developed that would cover us.

M^{me} France Gélinas: So if we were to make changes, if it was possible, how would it look?

Ms. Christine McMillan: We've made a recommendation. By the way, I was a policy adviser with the Ministry of Labour before I retired. I looked at it, and I thought there would be a possibility of providing innovation funding to the South East LHIN.

M^{me} France Gélinas: No, I mean on the ground. For the clients you serve, how would it change?

Ms. Christine McMillan: Right now, a health care provider makes decisions for people. For example, the caterer who provides the meals wanted to go on holidays, so without any consultation he went on holidays for a week, leaving the seniors without meals for 12 days.

M^{me} France Gélinas: Not good.

Ms. Christine McMillan: Not good.

M^{me} France Gélinas: Basically, if you had the money, you would hire your own staff? Your members would have more oversight as to who does what?

Ms. Christine McMillan: Yes. I think the model we envision is, when we go into a partnership with an apartment owner, that the seniors form their own executive committee and board, and they make the decisions and work with—there will always have to be a health care provider. But if the contract is with the health care provider, it makes a difference about who is in control.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. Jaczek.

Ms. Helena Jaczek: Thank you so much for coming in. We've heard from a number of providers of assisted-living services from across the province, and I think we have got the message loud and clear.

I'm just wondering, to what extent—obviously, this is a technical issue here—are the LHIN and the CCAC here in the southeast supportive of your desire for regulation changes?

Ms. Christine McMillan: I think they've been very supportive. In fact, we did meet with the board chair last year and with the executive director of the CCAC, and they were very interested in having the funding flow through them, and then we would work in partnership with them. But they were told that there was no regulation that would allow that to happen.

Ms. Helena Jaczek: Presumably, they would be supportive of a regulation change, since they've—

Ms. Christine McMillan: I would expect so.

Ms. Helena Jaczek: Well, we hope we'll hear from them that they are. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you coming out this morning.

Ms. Christine McMillan: There will be a package that will be delivered to you. Thank you.

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is the South East Local Health Integration Network: Donna Segal, chair. Thank you very much for coming in this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use all or any part of that for your presentation. If there's any time left over at the end of the presentation, we'll have questions from our committee. Again, thank you very much for being here. The clock starts ticking now.

Ms. Donna Segal: Thank you, Mr. Chair and members of the standing committee. My name is Donna Segal. I appear today as chair of the South East LHIN board of directors, a position which I have held for one year. Thank you for the opportunity to present to you today.

The LHIN believes that your mandate to review LHINs and their enabling legislation is really timely, and we look forward to the outcome of your review, to identify areas for strengthening this important element of what we see as local governance.

I hope to speak for about 10 minutes or so, leaving the opportunity for a question or two.

I'll start with an indication of some of my experience with the health care system. For more than 25 years, I was with the Ministry of Health and Long-Term Care, and then after with the Health Council of Canada, both providing me with experience that gives me some important context in assessing how and what our LHIN is doing as we move forward.

I began in the ministry, lo, many years ago as an area planning coordinator in the District Health Councils Program. I enjoyed assisting the councils to plan and advise regarding local health care services in keeping with government policy and direction and, conversely, interpreting local aspirations and experiences back to a ministry centralized in and managed from Toronto. But the DHCs were advisory; they had no funding or decision-making authority, and the larger organizations continued to invest more strongly in their relationships directly with the ministry rather than locally with the DHC.

Much later, the ministry established regional offices when other provinces were turning to variations of decentralizing and devolving planning and administration to introduce order, local sensitivity and accountability in order to address the fragmentation of service management and spiralling growth in health care expenditures.

What I observed then from my then-current position as the CEO of the Ontario Family Health Network were the

difficult decisions regarding the balancing of the scope of the services to be covered by the regional office, the health care provider community's frustration with their engagement with the office, and a level of decision-making authority which, frankly, still had funding decisions finalized by the ministry in Toronto.

This model demonstrated the weakness of half measures. It didn't achieve the predicted administrative cost savings; it didn't create closer relationships with the community and decision-makers; and didn't render planning and administration decisions to be more timely, more nimble or more responsive to the local context.

On another tangent, during this time when I was with the Ontario Family Health Network, I had the opportunity to appreciate the pivotal and underdeveloped position that family doctors had, not only in providing primary care, but also in enabling their patients to access needed services—again, a reference to patient navigation. It's this patient-navigation support role that is so important in helping to drive forward a system of care wrapped around the patient.

I draw on this experience as I watch the leadership and committed involvement of the primary health physicians in our region as they participate and collaborate in the development work of the seven health links, which entirely cover our region. We are one of the two regions in Ontario which have achieved this. We've had a rapid take-up of this approach, and the drive to make it work speaks to the local commitment and the willingness of the health care providers, including family doctors, to collaborate, to address the needs of the most complex patients within each health link. We have at least 85% of physicians in each link region collaborating, and in some links we've achieved 100% of family doctors, so there's terrific interest.

From 2004 to 2007, I spent three years with the Health Council of Canada. There, I witnessed the functional differences between regional authority models of health service management, which were in effect in many of Canada's provinces, and the LHIN model. The intent of Ontario's model was clear: to grow the capacity for system transformation in a manner which meets provincial expectations yet considers local needs; where the ministry sets policy and health system priorities and the LHIN, through system and service integration, promotes the improvement of the patient experience and ensures service value for money.

Lastly, and a key difference, the LHIN system retains local boards of directors for all funded health service providers as a means to ensure local oversight, local input and responsiveness to the local community.

Fast-forward through my term on the board of directors at Kingston General Hospital to now—as my husband refers to it, my failure in retirement as chair of the LHIN board. I remain convinced of the importance of the role of a local entity such as the LHIN, with appropriate authority and having engaged its community, including its patients and their families as well as health service providers, to:

(1) Plan in a manner which is patient-centred, not functionally provider-centred, and which promotes patient and family access and quality of service.

(2) Encourage, facilitate and build on collaborative relationships between health service and community partners to promote local systems of care that are integrated as seamlessly as possible from the patient's perspective and which optimize value for money.

(3) Make funding decisions and allocate funds according to government policy in a way which is sensitive to the overall design of services in the region, best meets local needs, aligns the priorities of diverse stakeholders, addresses key areas for improvement based on the analysis of local demographics and performance data, and highlights populations within the region as a focus for new programs. It strives to ensure that all individuals have equitable access to high-quality care.

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(4) Monitor and track health service provider fiduciary and service performance, ensuring their accountability for the appropriate management of funds and delivery of services that were funded.

You've already heard from Paul Huras at the outset of your hearings. Paul is the long-standing CEO of the LHIN. He has a long history and has been a guiding force in the maturation of the LHIN model. I won't repeat what he told you; I think we don't have the time for that, but I do want to reflect. In your version of notes that I've provided you, I have built in his comments and some further reflections on the South East LHIN's performance.

You will note that there are clear indications that the system's performance has improved. In short, the system's successes are in the realm of access to care, continuing integration of care and financial performance. The one thing I do want to point out with respect to the current financial stability of hospitals is that all seven hospital corporations in the South East LHIN's area have submitted balanced budgets for 2013-14, and several are projected to end the year in a surplus position.

Hospitals are to be congratulated for their efforts to systematically eliminate operating deficits without materially compromising access, quality and safety of patient care. But that's not to say that, from time to time, some hospitals haven't been challenged to live within their budgets.

The following is also worthy of comment. Far different from what I observed in my days with the ministry, it's clear to me that this region's health service providers have acknowledged that new funds will be scarce and that a pitch for special consideration to fund a deficit is unlikely to be successful. I observed a renewed determination to perform within funded levels and to work collectively to meet financial imperatives.

How have these successes been achieved? First, I want to give credit to the health service provider boards and senior leadership. In the end, it is their hard work, determination and commitment, which delivers the success. But I also want to suggest that the local yet objective re-

lationship of the LHIN to its health service providers has been instrumental in assisting them to achieve such successes.

Again, how? Well, I don't have a lot of time left, so I want to be brief:

- through capable LHIN board governance representing its community and committed to fostering patient-centred planning and service management;

- through capable staff: We have a complement of 50 staff;

- through structured and facilitative processes to manage accountability and introduce efficiencies;

- through engagement and addressing emerging patient demands: Particularly, a new emerging demand is now being evidenced through measuring the quality of patient care. We've been in discussions with Health Quality Ontario to determine how best to complement Health Quality Ontario's health-quality leadership and to support the delivery of quality services in our region; and

- through collaboration and support.

Three ventures come to mind. One example is of cross-border collaboration involving the Royal Ottawa Hospital and the Brockville General, for the divestment of psychiatric services provided in Brockville from the Royal Ottawa to Brockville. Through the collaborative efforts of the Royal Ottawa and Brockville General community mental health providers and the ministry, the two LHINs worked together to steer a successful outcome, and the services have been divested at this time.

A second venture I'd like to talk about is our Clinical Services Roadmap. It's a collaborative and detailed effort undertaken over the past three years with our hospital and CCAC partners, with the objective to address fragmented yet priority clinical services across the region. It hasn't been an easy exercise, but there have been some successes, one of the major ones being the learning opportunity provided in the development of regional thinking, trust and respect for mutual dependency.

The third area of collaboration is support to our health service providers. At the request of providers to help them develop the type of leadership skills required to work in partnerships, the LHIN has partnered with the Rotman School of Management to offer an advanced system leadership program. The intent is to support the providers to find the balance between their own organizational priorities and regional and system priorities, and to build the relationships necessary to enable the integration of services.

The last element that I'd like to identify is our achievements through integration. These are the opportunities which have been my priority in my brief tenure as chair. The first, which I don't want to belabour, is around health links, an important venture. I am amazed and encouraged by the cross-sector response to take part. We've been a stimulus, a seed and a catalyst for collective planning around the needs of the most complex patients.

The second initiative is around addictions and mental health redesign. We recognize through engagement that

there were significant gaps in our addiction and mental health systems in the region. We wanted, in that, effective redesign. We wanted to keep the redesign process patient-focused, so we enabled a task force comprised of patients, providers, clinicians and community service providers, who were supported by experts to identify the ideal patient journey. The intent was to replace the current episodic and truncated approach with an overarching, holistic and regional approach. Through a series of discussions, amplified by extensive engagement with patients and providers, the task force assessed a series of options for the redesign of the planning and delivery of services which might better address the ideal journey. Extensive engagement continues.

The third element is around hospital sustainability. The introduction of a new hospital funding formula will encourage more fairness in hospital funding levels across the province, but it will cause the South East to lose about \$30 million to \$40 million from its collective hospital allocation. That's a lot of money. In an effort to meet the imperatives of the reform, the hospitals are about to undertake a collaborative project to review the distribution and availability of hospital services across the region, in an effort to streamline service delivery.

I have deliberately focused on these strategic and important planning efforts, which have been in play since my involvement with the LHIN. This is the LHIN that I know, the LHIN that is committed to improving access to high-quality care for its residents, in collaboration with, and through the efforts of, its health service provider partners.

But, as with all systems, the capacity of LHINs can be improved, and we hope that you consider, in your review, amendments to LHSIA which will foster these improvements. In the absence of time, I won't elaborate.

Thank you very much for the opportunity to present.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have just over two minutes left, and it will go to the opposition. Mr. Milligan.

Mr. Rob E. Milligan: Thank you very much, Ms. Segal, for coming in today. It's always a pleasure to see you.

I guess you weren't able to elaborate on some of the implementations that you would like to see brought forward by government concerning improvements to the LHINs. Could you perhaps just take a quick couple of seconds to highlight those?

Ms. Donna Segal: Sure. They don't differ from many of the observations that have been put forward by others. We'd like to see greater involvement with primary care physicians, particularly the organized primary care physician corporations or processes—in particular, relating to their performance, not necessarily relating to their OHIP funding in that matter.

We don't have a position on public health, and I know that came up earlier. We have remained silent on that. Without question, we work closely with public health,

and the notion of working with them to continue or further efforts around health promotion would be fine.

Some of the issues that were expressed earlier were some changes in regulation or procedures regarding financial funding. I'm very sympathetic to the Oasis comments that were made previously. I'm also sympathetic to the comments that were put forward by the CCAC. Multi-year funding would be helpful, as would some of the easing of some of the regulations that, I don't think, were intended to be as strict and narrow as they have been interpreted.

Those are the two major ones but there are others.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for taking the time to make your presentation. We very much appreciate it.

Ms. Donna Segal: My pleasure.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mr. Ernie Hardeman): Our next presenter is the Ontario Public Service Employees Union, OPSEU: Rick Janson, campaigns officer, and Warren Thomas, president.

Good morning, gentlemen, and thank you very much for sharing your time with us this morning. You will have 15 minutes to make your presentation; you can use all or any of that for your presentation. If there's any time left at the end of the presentation, we'll have questions and comments from the committee. With that, the floor is yours for the next 15 minutes.

Mr. Warren Thomas: We'll talk fast so we'll have time for questions. Rick Janson is with me. He's our health care expert, and many here probably follow his blog. I know the government does because they phone, bitching about him, all the time.

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We represent 130,000 members. About a third work in a variety of health care settings, including hospitals, long-term-care homes, ambulance, home care, mental health, independent diagnostics, community health centres, public health, and Canadian Blood Services. We were the first union to sign up members at an Ontario family health team. We also represent health professionals in the province's corrections system and the Ontario public service members at the Ministry of Health and Long-Term Care. As a result, we believe we have a unique 360-degree perspective on health integration.

OPSEU was among the first trade unions to warn of impending issues with the local health integration networks. In 2006, we warned that the LHINs would be used to deflect public criticism from the real decision-makers. That not only came true but did much to damage the brand of the LHINs.

We warned that the LHINs would be used to implement the same kind of race-to-the-bottom competitive bidding we witnessed in home care and hospitals. The government said we were scaremongering, yet we note that the government now plans to have independent

health facilities enter into competitions this year with hospitals to perform such services as cataract surgeries and endoscopies. We are told this is only the beginning.

We warned that the LHINs would drive down wages as services got divested to community-based agencies. We should note that the Ontario Hospital Association recently advocated that the Public Sector Labour Relations Transition Act not require agencies to pay hospital wages to employees transferred to such community health providers. That's a declaration of war, folks.

The LHINs have gotten around such requirements by not publicly stating where hospital services were going, after permitting outpatient clinics to close under the auspices of hospital accountability agreements. Every time, we are told that these services will reopen in the community, but are never told when, where or on what scale. That makes it very difficult to assert workers' legitimate rights under PSLRTA.

We warned that the LHINs would help the government rationalize services and require patients to travel further to access care. We have seen this repeatedly in the decision to create so-called centres of excellence, even when there was no evidence to suggest that lower volumes performed closer to home threatened quality. The Windsor Regional Hospital recently fought and won this issue when Cancer Care Ontario tried to defund the hospital to make it stop performing thoracic cancer surgery. Windsor residents didn't want to travel to London when they could get the surgery done closer to home. Critical to the victory was the absence of any evidence by Cancer Care Ontario that quality or outcome would differ.

You may very well say that most of these decisions really reflect the direction of the Ministry of Health, and you'd be absolutely correct.

To create the LHINs, the government shut down seven regional ministry offices and effectively turned around and opened 14 in their place. OPSEU members lost more than 2,000 jobs at the Ministry of Health, only to see about 500 newly established at the LHINs. That's a quarter of the staff to provide oversight to 149 hospital corporations, more than 600 long-term-care homes, 14 community care access centres and hundreds of smaller community-based health providers. That's a quarter of the staff to do health system planning; a quarter of the staff to provide expertise and to seek public input. Make no mistake: This was doomed to failure.

To create the veneer that real decisions were happening locally, the government appointed nine-member boards to each of the regional LHINs when no board existed to oversee the provincial decision-making.

Where the key provincial decisions take place, there is no board. Where the key decisions simply get implemented, there is a board. We're not sure that this makes much sense. Anybody who attends a LHIN board meeting will quickly realize that any local decisions are being made by senior staff under the direction of the Ministry of Health, so why do we pretend otherwise? This is likely not news to you.

I'll note that during your briefing with the departing deputy minister, Saâd Rafi, government MPP Donna Cansfield said, "The LHINs tell me time after time that they do not have the autonomy you say they do. They do as you tell them to do." That is also our perspective. I note that Donna is not on the committee for the Liberals.

Our own hope for the LHINs was that the process around system transformation would be an open one and that there would be an opportunity for the public to have meaningful input into the decision-making process.

While the definition of integration is clearly spelled out, few of the substantive changes to local health delivery get treated with any kind of open process.

We're told there is no integration process if the services transfer outside the scope of the LHINs. We're told that there is no integration process if a health provider transfers services between two of its own sites, even if they are geographically distant from one another. We are told that there is no integration process if the changes are a result of a hospital meeting its accountability agreement. We are told that there is no integration process if a health provider independently chooses to close its doors.

When you think about it, there are very few opportunities to actually go through the integration process—not that it is particularly rigorous.

When we do have an integration process, often the details are so vague it would be nearly impossible for anyone to reasonably evaluate the merits of the plan. Often, we don't even know why the integration is taking place: What is it that the LHIN is trying to solve?

To give such an example, we were recently asked for input on an integration plan that would bring nurses from the Port Hope CHC to provide education and support to patients and staff at the Northumberland Hills Hospital dialysis unit. We were not told how many CHC staff that represented or what education would be conducted, especially when the hospital had existing certified diabetes educators already doing this work. The plan, which we received in December, was set to be implemented in January. The plan lacked any human resources component, leaving us to wonder how this was supposed to work, given OPSEU and ONA held bargaining rights for professional staff on this unit; nor was it clear who was paying the bill or what this cost. How is any stakeholder to reasonably evaluate such a proposal?

I'll turn it over to Rick now.

Mr. Rick Janson: We also note that infrastructure planning is not well integrated with the LHIN service-planning process. While the province continues to sink billions into new hospital infrastructure, the LHINs have been given the challenge of essentially emptying those buildings of services and patients.

We presented a report to the South West LHIN in 2010, suggesting the capacity planning for two new psychiatric hospitals in London and St. Thomas was both out of date and inadequate to local need. We pointed out that the existing aging facilities were working at capacity and couldn't understand how the new buildings could

open with fewer beds, amid an aging and growing population base.

What happened? Despite our intervention, the hospitals went ahead as originally planned.

The first, St. Joseph's Southwest Centre for Forensic Mental Health Care, opened in St. Thomas last year. When we visited a few weeks ago, we were told that all 80 funded beds were full and that patients remained waiting in the region's crowded corrections centres for lack of capacity. The only provision for the future was nine additional beds, which the centre could happily fill right now if the funding existed.

I should point out that here in Kingston, the province is about to make exactly the same mistake with the replacement hospital for Providence Care's mental health and rehab facilities. What we are presently seeing is not capacity planning, but wishful thinking.

Similarly, the Ajax and Pickering Hospital underwent an \$80-million expansion that opened in 2010. It increased the overall size of the hospital by 25%. That expansion is now full, and the Rouge Valley and the Scarborough hospitals are proposing another major expansion at the west Durham hospital as part of their merger plan. They feel the space needs to double. They argue an expanded west Durham facility is needed because so many Ajax and Pickering residents travel to Toronto for care in the absence of local capacity. With the new funding formula that follows the patient, that means health care dollars are also travelling away from the community where the services are actually needed.

So what are we recommending?

(1) That the LHINs themselves formally integrate with the Ministry of Health by becoming 14 regional offices responsible for all health care planning, not just the sectors presently identified under LHSIA. These regional offices should also include responsibility for establishing local service and capital planning. The goal of these regional offices should be to place an emphasis on equitable provincial access to quality care, as well as assessing regional need to establish reasonable capacity targets. Expert staff should be available to assist health care providers in resolving performance issues, both quality and financial, and to ensure public accountability. All accountability agreements should be with the Ministry of Health and posted online.

(2) That an expert panel be appointed by the ministry in each region to review integration proposals and seek community and stakeholder input, publicly reporting their final recommendations, along with the results of their consultations, back to the ministry. The public should have a period of no less than 60 days to respond to an integration proposal.

(3) That a process be established for provider integrations, including a template that establishes the purpose of the integration, timelines, cost comparisons, the impact on volumes, quality and access, as well as how the proposed changes will impact other health service providers and fit within the regional plan. The proposal should also include a report on the results of public engagement, that

not only establishes the who, when and where, but a summary of the substance of what was heard. Any proposal should clearly establish whether the recipient of any transfer process is for-profit or not-for-profit, especially in circumstances where the ministry is establishing a not-for-profit criteria, such as has been the promise of the action plan around community-based speciality clinics.

(4) The integrations process should include any substantive change in service delivery, whether that be a closure, a transfer, a merger or new partnership agreement.

(5) Transparency is the best disinfectant. Accountability works best when all business is conducted in public, including posting of the integration proposals and all relevant documentation in a way that is easy to find.

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(6) We would also strongly recommend that any public disclosure be accompanied by a "popular" summary of the proposal written in plain language. Similarly, the websites should be reviewed to make them more user-friendly.

(7) We would urge the government to strengthen accountability agreements to require health service providers to give reasonable notice of closure, except under circumstances that may be beyond their control, such as bankruptcy or fire. The ministry should be able to order such providers to remain open until such time services can be reasonably transferred.

(8) The ministry should undertake an evaluation of staffing needs at these regional offices to ensure that they have the capacity to undertake service and capital planning, accountability, integration and provider support. Ultimate accountability should reside with the elected representatives, including the Minister of Health.

Mr. Warren Thomas: So in closing, I'd just like to say that better than a decade of mismanagement has created what I would consider to be a horrible mess in health care in Ontario. The government should be ashamed of themselves, and the previous Tory government should be ashamed of themselves too, because they started down this road.

I hope that in your planning process you actually do a little more consultation with front-line workers—because if you're a patient and you can get a service, you get really good care. The trick is to get that service, because there's just not enough of it. There's probably one manager for every five workers in hospitals, which Dalton McGuinty recognized and still did nothing about, so the health care system, even out in the communities, is grossly over-managed.

Anyway, I hope you make some reasonably good decisions, but frankly, I don't have much confidence you will.

Thanks for listening, and time for comments—
Interjection.

Mr. Warren Thomas: Hey, sister, you gave us 10 years to be skeptical.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have just less than three minutes left, so the questions will go to the third party. Ms. Gélinas?

M^{me} France Gélinas: Good morning, and thank you so much for coming. You have given us a different sound, and I very much appreciate that you took the time to come and present to us today.

The model going forward would be with 14 regional offices, no more boards of directors, but the regional planning would be planning for the entire spectrum. Do you include fee-for-service physicians in there? Do you include public health units? Do you include EMS—everything?

Mr. Rick Janson: Yes, I think it would include the full range, because if you want an integrated health system, how can we just put half of it under the LHINs? It doesn't make much sense. If you look at the role of primary care providers, for example, it's key to the health system in terms of how it functions. They often are the gatekeeper to the system, and if they're not included in the discussions, it doesn't seem to make much sense.

M^{me} France Gélinas: We've heard over and over that it's the Ministry of Health that makes the decisions. The LHINs hold consultation or engagement, but we fail to see how whatever was told to the LHINs had an impact on the final decision. You're not the only one telling us that. In what you have put forward, how is it different? How do we make sure that if people mobilize and tell their new regional office that this plan needs to change—how do you make sure that it's active listening that leads to different decisions?

Mr. Rick Janson: I don't think we could ever guarantee that as long as there are elected officials, they'll follow exactly what people want to do. But I think there would be increased pressure to do the right thing if there was full disclosure. If we knew, for example, what costs were involved in any kind of transfer, which employees were going where, how this would impact local services, and this were all up online and publicly reported, and then the ministry decides to make the wrong decision, then I think there would be increased pressure to basically turn around that decision.

Right now, the LHINs make the decision, and there is really no avenue of appeal. When it happens, we get very little information up front, the decisions get made, and we have nowhere to turn. In fact, some LHINs specifically have requirements that if you're going to make a deputation to them, you can't bring up something that a decision has already been made on. So it's the opposite of appeal; you can't even talk about a decision that has already been made.

M^{me} France Gélinas: And the idea of appeal—is this something that you would see, a formal process for communities to appeal decisions?

Mr. Rick Janson: I think so. I think there should be some appeal process. I mean, ultimately, no matter what, it's going to be a political process at the end of the day,

and I think as long as the politics is there, that people will—

The Chair (Mr. Ernie Hardeman): We have reached the end of our time, and we thank you very much.

Mr. Warren Thomas: Can I just say—

The Chair (Mr. Ernie Hardeman): The reason you couldn't finish your answer is because the questioner took too long to put the question. Thank you.

Mr. Warren Thomas: Whatever, Ernie. All I know is this: 15 minutes for such an important issue is an insult to democracy—

The Chair (Mr. Ernie Hardeman): Thank you very much. We are trying to hear from as many people as possible. We thank you very much for taking the time to make the presentation.

FRONTENAC COMMUNITY MENTAL HEALTH AND ADDICTION SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is the Frontenac Community Mental Health and Addiction Services: Leonore Foster, member of the board. Thank you very much for being here. As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that for your presentation. Any time left after the presentation, if you so decide, will be used for questions and comments from the committee. Thank you again for being here, and the clock starts now.

Ms. Leonore Foster: Thank you, and good morning, and welcome to Kingston, to all of you. Thank you for this opportunity to provide to your committee our take on the effects of the act and on what we do in the Frontenac community in support of the recovery of people suffering from mental health and addictions problems.

In outline, I will introduce ourselves; give you an overview of our agency, to give you an understanding of what we do; give you our take on the effects of the act; and lastly, make some observations on our interaction with the local LHIN.

I'm Leonore Foster, as you heard, and I'm a board member with the Frontenac Community Mental Health and Addiction Services. I have over 20 years' experience of service to the community as an elected councillor for the former Pittsburgh township and the city of Kingston. I was a board member of the local board of health for five years and, while chair of the Federation of Canadian Municipalities' standing committee on social-economic development, I served on the Canadian Reference Group on Social Determinants of Health.

I'm a default presenter, as Dr. Duncan Sinclair, another board member instrumental in preparing this presentation, sends his regrets as he is out of town. Duncan was a senior administrative officer at Queen's University, retiring as dean of medicine, and vice-principal for the health sciences. He subsequently chaired Ontario's Health Services Restructuring Commission in the late 1990s.

Our chief executive officer, Vicky Huehn, is unable to be here today. She would answer most of your questions, but she is also out of town, at a business meeting in Toronto.

I'm speaking for a board of 10 directors, drawn from the community, and that includes four directors elected by the members who receive services from our organization.

Our agency began in 1972 as an experiment by two staff members of the former Kingston Psychiatric Hospital, who believed that, given the opportunity to live in the community with a bit of support, their patients would thrive. They rented student houses for the summer and found that the hypothesis was correct. In 1976, the agency was incorporated as Friends of the Kingston Psychiatric Hospital, with several rented houses, and by 1981, 24 people were housed in rental accommodations.

The social supports available to these tenants were scarce, and in 1982, funding was secured to assist the members with their daily living skills. As tenants' needs grew, so did funding, and the agency grew to an integrated addictions and mental health organization that provides a wide umbrella of services, including assertive community treatment teams, crisis services, case management, court support, support for those with addictions and problem gambling, and vocational services. We have over 200 staff members serving 3,000 people a year, and a budget of \$14 million. The building equity of the corporation is over \$14 million in 17 buildings.

In 2005, Frontenac Community Mental Health and Addiction Services became one of the first community mental health organizations to be successfully accredited by Accreditation Canada. In 2007, the organization was awarded the Award of Excellence by the Ontario Non-Profit Housing Association.

I'd also like to say that our executive director, Vicky Huehn, received the Queen's Jubilee Medal and also the Paul Harris award for her services to mental health and addictions.

Now to our take on the act: We recognize that our take is essentially confined to our experience with the LHIN for southeastern Ontario, but in conversations with other providers of health and health care services in the region, we believe our experiences with the LHIN over the past seven years are typical of other agencies like ours, whose services are community-based as opposed to institutionally based.

First, establishment of the 14 LHINs throughout Ontario has been a good thing. Collectively, they are slowly diluting the propensity of a central, Toronto-based bureaucracy to micromanage the different ways in which services are delivered in this diverse province.

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It was recognized, when the act was passed, that one size will not fit all and that regional sub-governances, LHINs, should be established to develop a variety of policy frameworks, with the objective of meeting province-wide goals related to the health and health care of the whole population.

Meeting those goals best demands that a variety of approaches be tailored to the environment and circumstances of each of Ontario's diverse regions. That tailoring cannot be done from the centre; it can only be done effectively by those who know and live in the regional environment. LHINs, in principle, were set up to fill this role. We say "in principle" because the act you are reviewing has yet to be more than fractionally implemented.

Ontario's LHINs remain very much under the thumb of the Ministry of Health and Long-Term Care in Toronto. LHINs still do not have the powers, the resources or the authority needed to do their specific job. Nevertheless, we believe that the devolved governance LHIN model should be retained in Ontario and that the LHINs should be given more authority and funding by the ministry to do what the act intends them to do.

Second, LHINs were established as planning and funding bodies, not as entities charged with operating any service-providing component within the health care system. Unlike regional health authorities in other provinces, Ontario's LHINs are free of the inherent conflicts of interest that are inevitable when a funding agency also carries selective operational responsibility for such things as regional hospitals and home care agencies.

There have been times in the past seven years when LHIN staff members seem to have wanted to cross the line and to provide direction on how to implement a given policy thrust. It is worthwhile, in your review, to emphasize the point that LHINs are to be sub-governances for the province in their particular regions, with the role to provide leadership in reaching decisions on what to do to best provide the regional population with the health and health care services they need. Under the act, it is the responsibility of the regional providers, in all their diversity, to figure out how best to do it for the people they serve. We recommend that the wisdom of continuing to separate the different functions of governing the regional system—a function of the LHIN—from the operation or management of its variety of components—a responsibility of the components—be featured prominently in the committee's report to the Ontario Legislature.

Third, it is apparent that the LHIN in southeastern Ontario—and probably all LHINs—has been seriously handicapped in its mandate by three factors:

The hand-off of responsibility from the ministry for decisions relating to regional planning and the implementation of those plans has been too tentative and too slow. That was undoubtedly wise at the start, while the LHINs were being organized, staffed and learning how to deal with their new responsibilities. But it is seven years later and now over time for the ministry to loosen, if not cut, the apron strings and let the LHINs have the authority necessary to discharge their mandates.

While responsible for leading regional integration of health and health care services, the LHINs' mandate for planning and funding those services extends only to some of them. This is akin to giving the coach of a hockey

team the authority to direct the play of only half the players on the ice and, at the same time, holding him or her entirely responsible for the outcome of the games. To a considerable degree, coupled with having the necessary resources flow to the team from sources separate from the locus of responsibility, that's mission impossible.

Lastly, the LHINs continue to be seriously handicapped by the very slow progress by the ministry to develop and implement the capacity to collect, store, share, analyze and otherwise manage health and health care data and information. Until you can get a handle on the data and information bearing on the work of an enterprise, coordination of the activities of its components—that is, optimal integration of its activities for optimum outcomes—is virtually impossible. To be successful in what they are charged to do, the LHINs must have the tools they need to do the job. Those tools are: a centrally determined policy framework providing the authority necessary for the LHINs to lead in the implementation of health information management within their regions; the necessary technical resources and personnel to support implementation of that policy framework; and the data and information essential for all of us to know the extent to which we are getting our money's worth, measured in terms of the health of the regional populations for which LHINs, under the act, are to be held accountable.

Finally, our observations on some interactions with our LHIN that have need for improvement—our LHIN in southeastern Ontario has a new chair, a very passionate chair, as you've heard earlier, and we are very hopeful.

First, we need time for consideration. We have experienced several instances in which our board has been required to sign off or respond to inquiries from the LHIN on very short notice. Like most such boards, we hold monthly meetings. Receiving material for consideration that arrives too late for inclusion on our regularly scheduled agendas or is required to be returned in the interval between regular meetings inevitably leads to rushed decision-making, and often by less than a full complement of the board.

Second, timely responses: We have experienced occasions when the turnaround by LHIN staff of urgently required material for a decision—that material can be material that the LHIN requires itself—has been delayed for overly long periods.

Third, there are poorly defined requirements at times. Our board has been required to sign documents which have very open-ended articles, such as committing the agency to comply with a policy which has not yet been formulated or defined. All requirements in the multi-sector service agreements we are required to sign should be finalized prior to our being asked to commit to them, or a process provided to later negotiate further additions.

Fourth, there are vague measurements and expectations. We find that what the LHIN expects by way of measurement of outcomes, in conjunction with evidence-based information and best practices, in partnership with people with lived experience, family members and providers, is ill-defined to the point of vagueness. We are

properly expected to produce the required results, but the LHINs are not content experts and should work more closely with the front-line organizations to develop appropriate ways of measuring progress towards these results. We have no problem with implementing the principle that those organizations that fail to meet the clearly defined outcomes adopted by the LHIN should not be funded.

In conclusion, the provision of the range of health and health care services the people in each of Ontario's regions need to optimize their health and well-being requires teamwork by the whole range of organizations who provide the necessary services; leadership from a governing body sensitive and responsive to regional diversity, and with the authority to allocate resources most appropriate to establish and maintain a genuinely integrated system of health and health care services; and effective and efficient management of the operation of each provider organization, like Frontenac Community Mental Health and Addiction Services, to serve those who depend on it.

The Local Health System Integration Act has as its purpose meeting these requirements. Full implementation of the act is essential in meeting its goals, and we hope you will recommend that the act be fully implemented, and soon.

Our sincere thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about a minute and half for the government side. Mr. Fraser.

Ms. Leonore Foster: I don't know if I can answer your questions, but I have one for you.

Mr. John Fraser: Thank you very much for your presentation. It's very clear, very well thought out, and really does speak to the evolution of the LHINs. We've heard a lot over the course of the hearings about the LHINs assuming more responsibility for things like the CCAC, public health, ambulance and primary care. I can see that in your submission here you spoke about inherent conflicts, which I think is very clearly expressed. Can you elaborate on that a little bit in the context of what I've just mentioned, in terms of those additional responsibilities that people suggested?

Ms. Leonore Foster: Well, the conflicts we suggested could happen were if the LHIN stepped over its line as governance in the area and tried to implement service itself.

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The people who do the service in the region are the ones who know. Anybody doing a job knows best how to do that job. We certainly do in our organization. That was the conflict that we were describing could happen, because we know what our job is; we do our job extremely well. For somebody else to step in and say how to do that job would require a lot of consultation with us. Consultation is, I think, key.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

Ms. Leonore Foster: Oh, you are good on time.

The Chair (Mr. Ernie Hardeman): The time has run out. We very much appreciated your presentation.

Ms. Leonore Foster: Thank you.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next delegation is not here yet, but the following one is, so we'll ask the Ontario Community Support Association, Terry Richmond, to come forward. Thank you very much for taking the time to come and talk to us this morning. As with the other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's any time left over at the end, we will have questions from the committee. With that, the clock starts ticking now.

Ms. Terry Richmond: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Terry Richmond. I am the executive director of Cheshire Homes (Hastings-Prince Edward). As well, I am the president and chair of the board of the Ontario Community Support Association.

Cheshire is a community support service agency providing attendant care services to people who live with permanent physical disabilities. Our services are provided in the western boundaries of the South East LHIN. Cheshire is also a member of the Ontario Community Support Association.

OCSA represents the home and community support sector in Ontario. Many members of OCSA are community-based, not-for-profit organizations that provide a wide variety of services that enable people to live in their own homes and help avoid inappropriate and costly placements of individuals in acute-care or nursing home settings. OCSA represents approximately 400 not-for-profit agencies across the province, including and not limited to home care providers, home support agencies, acquired brain injury services, hospice agencies, Alzheimer's programs, in-home respite programs, and attendant care services through outreach and supportive housing.

It has been widely established that maintaining individuals in their homes despite physical challenges, complex needs, or age-related issues is a goal well worth striving for, both in financial aspects and in terms of individual health and well-being.

OCSA supports a strong, sustainable health system where clients are the focal point, and it remains supportive of the principles that were laid out by the government when the LHINs were established. While there is more work to be done on LHINs, OCSA is prepared to and wants to work within the current structure. Dissolution of the LHINs would not improve the health system and could potentially cost a large amount of money to do so. It could also serve to distract from more immediate issues that impact the delivery of home and community care.

One of the key priorities of the health system has been the move in care from acute-care facilities to the community. The LHINs are best suited to plan this as they are much closer to the community.

In the South East—which is where most of my experience has been—much has been done to consult with all stakeholders and to look at opportunities for efficiencies. For example, several years ago the South East LHIN funded a consultant to look at back office efficiencies with approximately 52 agencies from community health centres, mental health and addictions, and community support. A community working group was put together, made up of service providers from the four sectors. A consulting firm was hired to put together a report on where and how efficiencies could be made. At the end of the report, the stakeholders involved questioned some of the report's findings and estimates of savings and refused to support the recommendations. The South East LHIN listened and allowed the group to use the report only as a reference document.

Between the agencies and the South East LHIN, several working groups were put together to address key areas. Today, a number of agencies have become hosts to other agencies for their financial, payroll and reporting needs. As well, after several RFPs, there are vendors of record for IT and for office supplies. This process illustrates the success we achieved as we worked with the LHIN as a team to address issues and to find efficiencies.

OCSA believes in smart integration and not just integration for the sake of it. Presently, there are a number of agencies working together in the South East to co-locate their services in one place with the intent that this will be better for the client. Within our LHIN, there are five stand-alone hospice agencies whose long-term sustainability was being questioned. Over the past year, the LHIN has worked with these agencies to try and come up with a solution that would ensure they would be there for the clients in the years to come. The agencies, with guidance, came up with a solution that will not affect client care but will take pressure off the agencies and allow them to focus on what is important for them: their palliative clients.

In the South East, before the development of the LHINs, agencies did not always have opportunities to collaborate or even share information with the rest of the system. In the past years, community support has been included at far more tables where they would not have been present in the past. This has been important for sharing visions of health care, best practices and for planning.

I think there is still much to be done to ensure better coordination and consistency among LHINs themselves. We believe it is important that each LHIN develop what is best for their part of the province. However, there may be programs that have worked well in other LHINs that might be beneficial for others to look at to determine viability in their area. For example, a service called Seniors Managing Independent Living Easily—the acronym is SMILE—was developed in the South East

several years ago. Clients who are eligible are able to decide who they want to provide these services. It may be a local service provider, but it also may be a neighbor. Around 1,700 seniors are remaining in their homes through this program, at a cost of approximately \$3,000 per client. In an area that is quite rural, from a client's perspective, this has worked well. To my knowledge, no other LHIN has looked at this or tried a variation of it. When something is showing success, why, then, would others not want to look at it?

We believe that having a regional perspective is of the utmost importance. A one-size-fits-all viewpoint is not the answer, nor is bigger always better. Currently, acute care seems to drive all planning. For many community support services, providing services such as attendant care, Meals on Wheels and volunteer drivers for appointments etc. is serving to keep people healthy and at home, but it may not be as measurable as the numbers of hips and knees that are being done in hospitals.

In my own agency, for example, the average length of service for attendant care for someone who lives with a permanent physical disability is 15 years. We have had clients on service for 30-plus years and who are not in and out of hospitals. Why is that? The reason is, they are receiving service, perhaps daily for a few hours, by a personal support worker who provides the consistency and stability that puts the clients' needs first. Without these services, these people would be unnecessarily placed and taking up space in acute-care beds, as many have needs greater than what can be managed in nursing homes. Within the South East LHIN, they have made an effort to understand these client-directed services and have funded a needs study to determine the future direction of this population. Unfortunately, with new money only going to seniors' services, there are limitations to what can be done, and with the ministry still setting the direction, the LHINs can only plan so far.

It is important to allow LHINs to more appropriately resource all not-for-profit community support services. The ministry needs to invest in community-based services in order to increase the capacity and infrastructure of community support services. These services can be the answer to getting and keeping people out of acute-care beds, but the agencies providing necessary care cannot continue to do what they do with no funding increases.

I think it is time to allow LHINs to exercise the authority that was set out in the current legislation. LHINs were supposed to be able to allocate and reallocate resources to provide the goals of an integrated health services system plan and, to date, these things have not taken place.

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It is essential not only for our clients but for the entire system that we continue to strengthen and promote community support. The maintenance of the LHINs, encouraging ongoing growth in the existing networks, and communication with the agencies within each geographic area and beyond will surely serve to preserve and improve our health care system. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about seven minutes left. We'll start with the third party. Ms. Gélinas?

M^{me} France Gélinas: Thank you for coming.

What I get is that you are quite satisfied that the LHINs are there. For the community support services, it has met—things are better. You're included at the table; you're more respected as an agency. You still struggle with some funding issues.

I would like to bring something to you that has been shared with us elsewhere, if you're comfortable to answer. Some people have been suggesting that we do away with individual boards of agencies and go from the ministry to the LHINs to regional boards. Were those for sub-regions of your LHIN, you would have a board responsible for every agency within that geographical area. Have you given thought to boards versus no boards? What would that mean for you, for your agency, and is this something you would support?

Ms. Terry Richmond: I think that for our agency personally and for OCSA, we would continue to support the individual boards across the province. We're not interested in having no boards for agencies to answer to. I think those boards are in tune with what each individual home support or attendant care program or hospice agency actually provides. And they do a lot of work. They do many, many volunteer hours beyond being board members. In some agencies, those very same board members may be delivering Meals on Wheels and assisting with service provision. So I don't think it makes sense to cut them out of the picture.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for coming. I think I can probably speak for all members of the committee in saying that we've been so impressed by the number of people we've heard in support of community support, keeping people out of acute care and long-term care, and by all the work that you do in bringing our attention to that really important work.

There have been some suggestions also to integrate primary care more into the LHIN and the LHIN having more responsibility for public health and some other agencies. I'm wondering: As community support service agencies, to what extent do you liaise, in fact, with primary care physicians and perhaps with the local public health unit? Could you elaborate on any connections you have existing?

Ms. Terry Richmond: I think that there's probably limited liaising with those groups, other than the work that is now being done through health links.

Ms. Helena Jaczek: Do you think that would be helpful?

Ms. Terry Richmond: I think that the health links piece is starting to put those pieces together in terms of doctors discovering and understanding better what it is that community support does. The doctors, I think, have been one of the greatest complications in revamping the health care system.

Ms. Helena Jaczek: Nothing has changed over time. Do you think, though, that this movement might assist in terms of trying to bring them more into being part of a continuum?

Ms. Terry Richmond: I think there's hope there. I'm hopeful for that.

The Chair (Mr. Ernie Hardeman): Okay; thank you very much. Mr. Milligan?

Mr. Rob E. Milligan: Thank you for coming this morning. I've had this conversation before with many other individuals in the health care system regarding the LHINs. I agree: One size doesn't fit all. One of the challenges I see with the LHINs, though, from a local flavour, is that—and I'll give you an example. The Central East LHIN, which encompasses my riding, from Trenton all the way into Scarborough, and encompasses Scarborough, up to Haliburton—it's a rather large geographical region. One of the criticisms that I've heard is that the board doesn't necessarily reflect stakeholders from a local standpoint. What would you suggest that would actually give them a little more local input at the board level?

Ms. Terry Richmond: I'm not sure, for Central East. It certainly has not been my experience in South East. Our LHIN has been very engaged with agencies. They're involved in local networks. They meet with the variety of the people that they fund on a regular basis. They really have gotten quite a good insight into what it is that we all do, as diverse as the health care system is. Perhaps Central East could look to their neighbours to see how they've accomplished and achieved those things.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It was much appreciated.

HOTEL DIEU HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Hotel Dieu Hospital. Michael McDonald, the chief of patient care and chief nursing executive, is here. Thank you very much for joining us this morning. As with all delegations, you'll have 15 minutes to make your presentation. You can use all or any of that for your presentation. If there's any time left at the end, we'll have some questions and comments from the committee. With that, the clock starts ticking now.

Mr. Michael McDonald: Thank you, Mr. Chair, and thank you to the committee for letting me present today. I am the chief of patient care at Hotel Dieu Hospital. Hotel Dieu Hospital is located within the city. It's an ambulatory care hospital located just a short distance from this hotel. We see about 500,000 patients annually, and we provide a wide range of programs.

Today, I'd like to speak to you about one particular program at Hotel Dieu: the Total Joint Replacement program, a collaboration between Hotel Dieu and the South East LHIN, which is really successfully balancing local and regional health care needs and providing superior orthopaedic care to patients of the region. Hotel Dieu had

the idea of implementing an innovative short-stay joint-replacement program in order to accomplish three goals—this is for many of the patients of our region requiring hip and knee replacement: to improve surgical wait times; to improve the quality of care and outcomes; and to boost patients' satisfaction with their health care experience. The South East LHIN supported our plan and invested seed money to launch the program in 2009.

Since that time, the Total Joint Replacement program has delivered striking results. We started out quite small, actually, with about 60 or 70 joints per year. Over the last five years, it has grown to about 180 joints. At the outset, surgical wait times for hip and knee replacements in the region dropped, and the average length of stay for a patient at Hotel Dieu was two days, compared to other hospitals which had a length of stay of four to five days in hospital. Our intensive pre- and post-op physiotherapy means that none of our patients are admitted to rehab hospitals for rehabilitation.

The level of patient satisfaction is extremely high. This past November, Hotel Dieu topped a list of small, large, academic and community hospitals where patients were surveyed by NRC Canada about the quality of care they received during an overnight stay. One hundred per cent of the overnight patients at Hotel Dieu surveyed between April 1, 2011, and March 31, 2012, rated their overall care as good, very good or excellent.

We also know, through orthopaedic reviews conducted by our CEO and orthopaedic surgeon, Dr. David Pichora, that the program has achieved a more integrated role within the regional health care system than comparable programs in other provinces.

Given this success, accomplished with the South East LHIN's support, we are leaders in this model of care, demonstrating that it can improve access to surgical care for patients, improve wait times and maximize our efficiency as an outpatient care centre.

We are well positioned to share our clinical pathway with other hospitals in the South East LHIN, which we have done. We're also translating components of that, such as the centralized intake system, into a regional model for surgical intake. This is what integration is all about.

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This system is an important step toward building a regional hip-and-knee program across the South East LHIN. It shows how balancing local and regional needs can translate into structural changes that benefit patients in our own community and across the region. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have considerable time; we have 11 minutes left. We'll start the comments with the government: Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you, Mike, for your presentation. My own experience in my own LHIN has been a very good one. I'm from the riding of Oakville, where the Mississauga Halton LHIN is.

You've given what I think is a very good example of a kind of micro-project that was performed, where the co-operation between the LHIN and the hospital was a very good one. Are there other areas that you're planning on working on, or are there other examples of where you think that this type of co-operation would be the sort of thing we should be following up on? These numbers are impressive; that's what I'm saying. Could you apply this to other areas, and what would you suggest going forward for this committee that would make the LHINs work better?

Mr. Michael McDonald: Another program that we're working on with the LHINs is the bariatric program. Prior to last year, we did not have a bariatric program in the South East LHIN, so there were patients—approximately 300 of them—leaving our region and going to Toronto and Ottawa to get their surgery.

We started a program approximately a year ago—an intake centre. We handled the pre-surgery and post-op follow-up with the patients. The patients still do go to Toronto and Ottawa, but they don't have to go as many times, and they can be followed here.

That program was so successful that the ministry, with the LHIN working—we were able to get the medical program. So now we have two parts to the bariatric program. The last part would be the surgical part. The idea would be that we'd be able to provide that service to this entire region so that patients would not need to leave our region to go to Toronto and those places to work.

Working with the LHIN is working on new ways of models of care and looking at ways of improving access to the health care system. With new techniques on anaesthesia—things like that—we're able to now provide things on short-stay programs, so giving patients better access.

Mr. Kevin Daniel Flynn: Still time?

The Chair (Mr. Ernie Hardeman): You have about a minute left.

Mr. Kevin Daniel Flynn: Okay, great. This will be a short one, then. There are people who believe that the LHIN is a sound organizational concept, but it could be improved upon, or it's time to review it and see if there are ways to improve upon it. What advice would you give to this committee as to ways it could be improved?

Mr. Michael McDonald: We work very closely with the LHINs. One of the issues that has come up many times is that when we're working with QBPs, for instance, and we're trying to deliver the care, and we're working with the LHINs to—we have questions for the ministry, and sometimes those questions take a long time to be answered. So the LHINs are putting the questions out there, but sometimes the response back from the ministry with the answer is delayed. So improving that time for communication, especially when it comes to things like the quality-based procedures, would be a great improvement.

The Chair (Mr. Ernie Hardeman): Thank you very much for your questions. Mr. Milligan?

Mr. Rob E. Milligan: I'm fine. I don't have any.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Gélinas.

M^{me} France Gélinas: I thought I knew your hospital way better than I realized. You're an ambulatory care hospital, but how many beds do you have?

Mr. Michael McDonald: We don't have any beds, per se. We do have a short-stay surgical program, so patients do have a short stay between one day and two days. But the balance of that is ambulatory. So we don't really have any beds, like in-patient beds to stay.

M^{me} France Gélinas: That's what I thought.

Mr. Michael McDonald: Yes. So we're not like St. Joseph's, for instance, where they have 30 beds and they're an ambulatory centre. We don't really have any beds, but we do run short-stay programs—preliminarily, the short-stay hip-and-knee program.

M^{me} France Gélinas: Okay. So, basically, you came up with this idea and, through seed funding from the LHIN, it came to fruition and got the good results you shared with us. I'm trying to see the value added at the LHINs. Do you think you couldn't have been able to convince the ministry to invest into seed money to do something like that?

Mr. Michael McDonald: I don't know. I know that the LHIN really believed in this and could see the regional effects of it, so we were able to get the money that way. I can't answer your question of whether I could have convinced the ministry or not.

M^{me} France Gélinas: That's okay. Piggybacking: I really want to see what the value added of a LHIN is for a hospital like yours. What is the role of the LHIN? Does it help to have a LHIN here, except for the seed money that you talked about?

Mr. Michael McDonald: Yes, I think as we move forward as an ambulatory centre, building on what is possible in the health care system, working with the LHIN, they have a very good understanding of what we are and where we're going. I think that, working closely with them, there's an understanding. And so, when we come up with ideas and we present our ideas, they listen, and they always have kind of a regional look to it as well as a local lookout. We have a very good relationship working with the LHIN, and I really do see the value in working with them.

M^{me} France Gélinas: Has your relationship with other parts of the health care system changed because of the LHINs, either with home care, long-term care, community care or mental health?

Mr. Michael McDonald: Yes. I think that the LHIN is bringing a lot of those organizations—especially with health links, for instance—to the table, and then encouraging us to work together to understand the system as a whole.

M^{me} France Gélinas: You mentioned when you were asked how you make things better that sometimes it takes a long time to get answers. Do you put this delay at the level of the LHINs, at the level of the government, at the level of communication between the two, or all of the—

Mr. Michael McDonald: The level of communication between the two, I would think. For instance, recently we were looking at cataracts, trying to find out if we're able to get more cataracts and so on. There have been a number of calls placed to the ministry, but we have not heard back from the ministry with regard to an answer on that.

M^{me} France Gélinas: Not heard back, or did they redirect you to the LHIN, or simply—

Mr. Michael McDonald: No, the LHINs made the call to the ministry.

M^{me} France Gélinas: Oh, it's the LHIN who made the call on your behalf?

Mr. Michael McDonald: Yes.

M^{me} France Gélinas: Did you try calling the ministry yourself?

Mr. Michael McDonald: We have not.

M^{me} France Gélinas: No? You go through the LHINs?

Mr. Michael McDonald: We go through the LHIN.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you taking the time. Very helpful.

Mr. Michael McDonald: Thank you.

PRINCE EDWARD COUNTY COMMUNITY CARE FOR SENIORS ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is the Prince Edward County Community Care for Seniors Association: Debbie MacDonald Moynes, executive director, and Margaret Werkhoven, president and chair.

I guess I must have introduced someone in their absence—but thank you very much for being here. If you would be so kind in your opening presentation to make sure that Hansard knows which one of the two arrived today. You will have 15 minutes to make your presentation. You can use any or all of that to make your presentation. If there's any time left over, we will have questions and comments.

Ms. Margaret Werkhoven: Thank you. Good morning, Chair Hardeman and honourable members of the Standing Committee on Social Policy. My name is Margaret Werkhoven, and I am the president and chair of the Prince Edward County Community Care for Seniors Association, a retired superintendent of education with the Hastings and Prince Edward District School Board and a founding member of the board of the South East Local Health Integration Network.

With me today was supposed to be Debbie MacDonald Moynes, who has been the executive director of this health service provider agency for over 30 years. I'm very sorry that she wasn't able to join us; she had a dental emergency and went to see the dentist this morning. She hoped to be here but, despite a fair bit of Tylenol, she has had to go home rather than coming. I know that you would have enjoyed having her, because she is someone who has been in community support

services for a very long time and knows all the answers to any questions that you might have about our services.

Our agency, a member of the Ontario Community Support Association, exists to support seniors living at home. We operate with eight full-time staff members and seven contracted nurses, and with the support of 500-plus volunteers and a governing board of 10 elected members. Our annual budget is approximately \$500,000; 60% of our budget is funded by the South East Local Health Integration Network, and the remaining 40% by fund-raising, donations and client fees.

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A major source of our revenue comes from two thrift shops we operate in Picton which are staffed exclusively by volunteers. The community support services we offer throughout Prince Edward county include Meals on Wheels, congregate dining, transportation for medical appointments and shopping, foot care clinics, walking programs, home maintenance, respite, home help, rural route and telephone reassurance, friendly visiting, and help with forms, including income tax. In short, we provide whatever services seniors identify as needed to continue to live at home. On an annual basis, we provide support for about 1,000 seniors, using over 15,000 volunteer hours.

Your committee's task, as we see it, is to review the Local Health System Integration Act. Our task, as we see it, is to give you our perspective on our South East Local Health Integration Network and, by extension, on the LHIN model. This is a homegrown presentation. We don't have the resources to supply you with a comprehensive and sophisticated package of materials in support of the statements we make. Our views are based on the diverse personal experience of two individuals who are deeply involved in their communities and passionate about their agency's work, and who believe that the way to create a system of health care that is effective and sustainable is to pay more attention and provide more support to community-based health care and to foster a culture of disease prevention and wellness.

The basic question that we believe you are addressing is, "Do we keep the LHIN structure set up in 2005, modify it, or scrap it and start all over again?" Our response would be, "Keep it and tweak it." We have to say up front that it would be very helpful to all of us in the business of providing health-related services in our communities if you could all just speak with one voice on the matter of LHINs.

LHINs are not yet perfect in practice, but the basic concept of local management of health care, including planning, coordination and funding, vested in an organization which is independent of current health structures, makes good sense to us. Wondering from year to year and from election to election whether the LHIN structure will endure creates a level of uncertainty in the system that is counterproductive. It reminds me, frankly, of teachers who used to say, when new program initiatives were introduced, "Another bandwagon. This too shall pass."

The chaos that would inevitably ensue with a brand new approach would set us all back and would distract us from our main business of providing support for seniors. One thing I learned from 35 years in education is that you have to assume a five-year implementation cycle for a new program initiative. The LHINs have a huge challenge. They are not trying to implement a program or two; they are responsible for transforming a complex and multi-tiered health system. They need time and support from all of us to achieve that transformation.

We would give our local South East LHIN a strong B-plus. I'd venture an A-minus, but you might accuse me of having a bias. I can tell you from personal knowledge that the South East LHIN has a hard-working and dedicated chief executive officer and staff, along with a talented chair and board members that take their responsibilities very seriously.

We believe that together they have done a good job in a number of key areas. They have engaged local communities in meaningful ways in the development of three Integrated Health Service Plans through the use of citizens' forums, open houses, and Web-based surveys. They have found ways to involve primary care physicians not covered by LHSIA in developing a road map to coordinate hospital and clinical services across southeastern Ontario. They have given community support service agencies a place and a voice at tables to which these agencies had not been invited in the past. They have made collaborative governance a priority and have had, since 2006, a collaborative governance team with cross-sector representation. They have established seven health links which cover the whole of the LHIN and which are seen as a very positive step in care coordination for our most vulnerable citizens.

There are 120-plus health service provider agencies in the South East and about 1,000 board members associated with those agencies—volunteers who work hard to support their individual agencies and who have worked together in ways not thought of, let alone carried out before LHSIA, to achieve the vision for health care articulated by the ministry and by the LHINs.

The LHIN has made "accountability" a word with force and power among health service providers in southeastern Ontario. When our South East LHIN was first set up, its staff and its board had to work very hard to be taken seriously by the big players; that is, hospital and CCAC administration and boards. Hospitals especially were accustomed to running deficits and asking the ministry for bailouts, and seemed to believe initially that life shouldn't be any different under the LHIN. Because LHSIA gave the LHIN the power to make them comply through performance improvement plans and to make them balance their budgets, they did.

In the intervening years, the tone has changed significantly. Hospitals and the CCAC and their CEOs and boards make public statements about the direction of health care which echo those of the LHIN and its board. The collaborative relationships among the seven hospitals in the southeast are stronger.

The LHIN has also drawn community support agencies into discussions with hospitals and the community care access centre, which are now making far better use of our services than they once did. Emergency room diversion programs and hospital-to-home transition programs have helped get frail patients home from hospital and keep them out of emergency rooms. Those connections between hospitals, the CCAC and community agencies still have a long way to go, but they are well started, from our perspective.

What does our LHIN need to do to get an A-plus from us? First, they need some help from you, the legislators. They need to have the LHSIA implemented for real—and extended. Local health networks were intended to provide community-based decision-making. Central decision-making—that is, decisions made on behalf of local communities by the Ministry of Health and its regional offices—was to devolve to local integration networks. It doesn't seem to have played out that way. The regional offices were dismantled, but the ministry itself has grown significantly larger. Many of the big decisions—for example, re base funding—still come from the ministry. As a result, the flexibility of the LHIN in dealing with the funding needs of its health service providers seems more limited than it should be.

As well, two significant groups were not included in LHSIA: primary care physicians, except for those associated with community health centres; and health units. The South East LHIN has worked hard to cultivate good working relationships with physicians and the three health units in the region. We do not know if more formal relationships with these groups are necessary, or even possible, but we do believe that local system health planning will only be successful if there are strong connections among LHINs, physicians and health units.

Our focus is on keeping seniors in their own homes for as long as possible, through programs which support their good health and well-being, and which help them to continue to feel part of their local community. We hear much talk from both the ministry and our LHIN about the need to shift focus from acute care to community care. It feels mostly like talk, though. The indicators in our M-SAA, for example, are all derived from acute care targets. While we appreciate that our agency's work has an impact on wait times and alternate-level-of-care days and the number of emergency readmissions, we think that our work would be seen to have more value if some indicators referred specifically to the work we do.

A significant issue for us in our sector is reliable base funding. Although the ministry mandated a 4% increase in funding for community-based care, that money must be spent on specific projects identified by the LHIN to address provincial and local priorities. None of it can be used to support increased base funding for agencies like ours. The message is clear: Community support services agencies will have more to do, and will have to fundraise harder and recruit more volunteers to do it.

If the work of our agency were viewed more positively for the impact that it has on seniors living successfully

at home—and our staff, for the equally important work they do for those working in other parts of the health care system—then perhaps it would be easier for the ministry and the LHIN to see that funding of the CSS sector is just as important as funding for the hospital and CCAC sector. It might also make it easier for us to recruit staff into community-based health. The wage differential between equally qualified staff working in hospitals and CCAC settings and in community settings makes it difficult for us.

I'd like to introduce Debbie MacDonald Moynes, who—Tylenol-enhanced and all—is here. Thanks, Debbie, for getting here.

I was talking about the wage differential between qualified staff. Higher wages suggest higher value. We don't see a ready solution, but we want you to know of our dilemma. Essentially, base dollars have to shift, and LHINs need to be able to make that shift.

In the early years, our LHIN has, of necessity, given much of its time and energy to the organizations to which the bulk of health funding has traditionally gone. One of its challenges in shifting its focus to community-care-based organizations is that there are so many of us.

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One of the original selling points of the LHIN made-in-Ontario model was that it retained the governance structures already in place. We see our LHIN struggle with keeping track of 120-plus health service provider agencies and boards. While we believe that integration of both services and governance is sometimes a good option, we want to see integration happen only when it is clear that integration will lead to improved service for clients and not just to simpler administration for LHINs. Our staffs and boards have a wealth of experience and commitment. We would like to see our LHLN take better advantage of that experience, by setting up structures to ask for and take our advice more often. We are guided by the same vision and are pursuing similar objectives. We need to work more closely together, at both the staff and board level, as partners.

There have been tool kits created to help boards learn of their expanded responsibilities in a LHIN environment, but there are no guidebooks that we know of for how LHINs should work with their many providers and boards. Developing good relationships based on mutual respect is essential and requires exceptional skill and sensitivity on the part of the partner with more power; that is, the LHIN.

To summarize: We are proud of the work that our Prince Edward County Community Care for Seniors Association does in our community, with financial support from the taxpayer and with incredible support from volunteers in the community itself, support which often goes unnoticed and undervalued until it is put in jeopardy. We appreciate and value the work of our LHIN, as well, and believe that the better way forward for the province of Ontario is to work out the kinks in the LHIN model.

Thank you very much for listening to us this morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do want to recognize the arrival of Debbie MacDonald Moynes, the executive director, who I'm sure was detained by a painful experience. It was mentioned that you'd had a dental appointment. With that, we just have a very short question from the PC Party. Mr. Clark.

Mr. Steve Clark: Thank you very much, Chair, and I apologize for being late. I was at one of my local chamber of commerce meetings. I want to extend to you best wishes from your member of provincial Parliament, Todd Smith—

Ms. Margaret Werkhoven: Thank you.

Mr. Steve Clark: —who was unable to be here, but he wanted me to make sure that I extended his best wishes on the work that you do in his riding.

One of the things that I did catch as part of your presentation was a reference to fundraising. Do you see that the LHIN model, the way it has been created in the province, has required that more community agencies have had to fundraise? I know in my own riding, in Leeds and Grenville, that's a big concern: the amount of health care dollars that now have to be fundraised in the local community. Is that something that is a big issue in Prince Edward?

Ms. Margaret Werkhoven: I think from a historical perspective, that's a question for Debbie to address.

Ms. Debbie MacDonald Moynes: Is that how we turn it on?

The Chair (Mr. Ernie Hardeman): It'll start on its own.

Ms. Debbie MacDonald Moynes: It comes on by itself?

Mr. Steve Clark: It's magical.

Ms. Debbie MacDonald Moynes: Thank you. Fundraising is something that we've always had to do in the community support services sector and those agencies that support seniors, primarily, to live at home, through Meals on Wheels and transportation and services such as that. Because of no increases to base funding, that's part of the reason why the fundraising has to continue and seemingly continues to grow.

Ms. Margaret Werkhoven: I just—

The Chair (Mr. Ernie Hardeman): Very quickly.

Ms. Margaret Werkhoven: Just to say that fundraising is significant for us, but it's also something that we wouldn't want to see disappear altogether, because fundraising in a local community gives a community a sense of ownership. When you see what happens with the sense that hospitals have when—

The Chair (Mr. Ernie Hardeman): Thank you very much.

Ms. Margaret Werkhoven: Okay. Is that it?

The Chair (Mr. Ernie Hardeman): That does conclude the time.

Ms. Margaret Werkhoven: Thank you very much.

The Chair (Mr. Ernie Hardeman): We thank you very much for your presentation.

CENTRAL EAST REGIONAL SPECIALIZED GERIATRIC SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is the Central East Regional Specialized Geriatric Services: Kelly Kay, interim executive director, and Glenna Raymond, chair of the board. Good morning, and thank you very much for being here. As with the previous presenters, you will have 15 minutes to make your presentation. You can use any or all of that time for that presentation. If there's any time left over, we will have questions from our committee. With that, your 15 minutes starts now.

Ms. Glenna Raymond: Thank you very much. Good morning, Mr. Chair and members of the committee. I'm Glenna Raymond. I'm pleased to be here along with Kelly to speak with you this morning.

Central East Regional Specialized Geriatric Services was actually created by the Central East LHIN to improve coordination and system-level planning of specialized geriatric services. Our current strategic priorities include fostering excellence among specialized geriatric service providers; improving care for frail older adults, with an aim to keeping them at home; and increasing awareness of age-related needs. We work as a regional system to create that person-centred system of care together.

The RSGS is pleased today to participate in your review. We would like to share some experiences and some examples that illustrate our work within the Central East LHIN to improve availability and coordination of services. These experiences and examples I hope will illustrate for you an effective partnering between older adults themselves, their care providers and the local health integration network, a network that is keenly aware of and responsive to the needs of its communities, which is possible within the umbrella of the current legislative framework.

Ms. Kelly Kay: Hello. My name is Kelly Kay. I will try to keep our comments fairly short so there's an opportunity for questions.

In the Central East LHIN, specialized geriatrics includes several formal programs that are listed as examples in your handout. To set the context for our region, we have shared some information from a local study of health needs and system capacity that was recently completed by our organization. This planning work has been critical to informing priority setting and service planning for frail older adults across the Central East LHIN. We have provided details about the population of frail seniors that is the focus of our work, and you'll find that on the front page and on the second page as well.

Recently, the advice of the RSGS was sought by the Central East LHIN to inform more than \$27 million in community investments, including services for older adults. While the act empowers the LHINs with the responsibility for resource allocation, it also enables advice from the field to inform these decisions and provides the

mechanism and flexibility for local innovation and implementation.

The expansion of geriatric assessment services illustrates service design and implementation that prioritizes community engagement. Our consultative approach involves multiple partners and prioritizes the input of older adults and primary care providers. As a result, access to coordinated interprofessional assessments and interventions for older adults experiencing frailty and complex health concerns is expanding in our region.

The focus on interprofessional teams and flexible funding parameters allows us to address both regional and local needs in a cost-effective manner. This optimizes health human resource capacity and leverages local support. I offer you an example of that leveraging in the handout, whereby there are 11 organizations involved in this network of providers offering geriatric assessment services that are hosting a total of 100 individuals who are providing direct service, and also supporting that work with an additional 20 providers coming from their own organizations.

The RSGS has also convened a senior-friendly hospital working group, which includes representation from all nine hospitals in our LHIN. The structure of the legislation enables such collective work, including, in our case, the development of plans that build on provincial priorities and impact the acute-care experience for older adults. This approach for collective action locally holds promise for knowledge exchange of best practices and efficient use of scarce resources and expertise.

Addressing the needs of frail seniors requires a diverse group of partners and contributors, some of whom are not within the current LHIN scope; for example, some primary care providers. We need to find continued ways to bring multiple stakeholders and sectors to the table for a shared purpose.

In collaborative arrangements, governance is complex, and time and attention is needed for stakeholder communication as not all are operating under the same parameters. System design and improvement initiatives require front-line caregiver involvement. Their presence is critical to informing the long-term plan; however, the short-term cost of their involvement is the availability of patient appointments.

Ms. Glenna Raymond: Some things that we want to pay attention to in driving for the future: We want to ensure that there is equitable access to specialized seniors' services across all areas of a very diverse geographic area and that the planning for those services is based on solid data and capacity- and needs-assessment studies like the ones that we've completed locally. Secondly, we need to help address the public's understanding of the options and opportunities that are available to them in services, and we need to advocate for the best care for older adults. We're very pleased that the public and providers together are engaged in advising the funding allocations that make those opportunities possible.

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Thirdly, while we have seen providers accept accountability beyond a single organizational focus and they have come together as a network with accountability, we need to find better ways to measure the impact of that work and the impact on the health of the population beyond service utilization measures, like system volumes or counting visits, for example.

In addition, the collective work enabled by the legislation has tremendous benefits, but it is essential that the challenges are best understood and addressed with local flexibility, with opportunity to leverage local relationships and build local capacity. Both users and providers have expertise to inform new programming and resource allocation, and they should be supported to participate at a system level.

The enabling framework needs to be strategically aligned with the provincial health care priorities, but we recognize that this engagement takes time and has implications for short-term service delivery. The governance complexity is because there are multiple partners and stakeholders involved in any initiative, and yet that collective action is where the tremendous benefit comes from.

We hope we've left time for your questions and discussion, and we hope that some of these examples stimulate your thinking about what's working well and where there may be a need for increased attention.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We do have about seven minutes left. It starts with the opposition. Mr. Milligan?

Mr. Rob E. Milligan: Thank you very much, ladies, for coming here today. It's always good to see you.

I guess you've sort of touched on one of the things that I hear consistently from patients or constituents who have loved ones who have received service. It's not necessarily the service that they've received per se, but what I'm hearing is this concern: that the current model that's in place for the LHINs—I don't know if the money flows are a problem or an issue. But it would seem that in the shift to community-based services, there isn't the money—even though the current government has said there is money and that's the focus. But what I'm hearing back is that those services aren't always necessarily in place to provide the services that are required. Of course, the area, given the demographics of Northumberland county, is quite an elderly, retirement community in a lot of senses. So this is what I'm hearing. Is this a concern that you have? How do we expedite, given the LHIN's role in how we get funding from the government, to make sure that those services are in the community and people are getting the care that they need?

Ms. Kelly Kay: I think you raise a very good example. Thank you very much. That's something that's of great concern to the people who live within our region. I think that that has helped to inform the decision-making that our LHIN recently went through to direct \$27 million towards community investments. A large proportion

will impact directly the care of frail seniors, which is really intended to help keep people at home. That was what we heard from seniors and their families: that they really want to stay at home as long as possible.

We worked to advise our LHIN, which responded by directing investment specifically for that purpose—so the creation of new positions, the expansion of geriatric assessment teams from four to 10, the creation of system navigation roles that will help to support people move through the system, which we also hear to be a challenge for individuals. Certainly there is a team that has been located in the county that you speak of. I think that that's where we've seen an example to have the opportunity—

The Chair (Mr. Ernie Hardeman): We'll have to cut it off there.

The third party: Ms. Gélinas?

M^{me} France Gélinas: Two things that you mentioned: the first one having to do with bringing primary care providers into the tent; and the second one, not being happy with indicators. I'll start with the first. Locally, do the primary care providers feel that they're ready to come into the tent?

Ms. Glenna Raymond: I think that one of the very successful efforts that the RSGS has been able to engender is providing an opportunity and a forum for those providers to come together. That may not have happened previously. By inviting them, encouraging them and including them in the decision-making and the discussion at every stage of the design work, whether it's part of the governance board, where we have willing primary care providers sit as members of the governance team, right through to the programming and advisory work and design work that the staff are carrying out—I think there is a sense of readiness to participate very much.

M^{me} France Gélinas: My second, about indicators: Do you have input as to what kind of indicators you will be evaluated on? Some of them don't work for you, obviously.

Ms. Kelly Kay: Yes, we do. In fact, part of the task of our design work is to define the indicators that make a difference in terms of specialized geriatrics. While visit volumes do have relevance—not to say that that's not an important indicator—there are other indicators that are particularly important to a frail senior population, where visits are much longer, so volumes look a lot lower when you compare them against things like acute-care visits. We certainly do have that opportunity to influence the metrics that are to be collected.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for coming in and explaining about the model that has been instituted here in Central East by the LHIN.

I'm just a little puzzled. What is your relation to the CCAC?

Ms. Glenna Raymond: The CCAC is a member of our network as well. They have a position on the RSGS board and are fully engaged in the work that we do as

well. But the RSGS is a broad collection of all providers, including community support, primary care, the acute-care hospitals, the specialized mental health sector and the CCAC.

Ms. Helena Jaczek: So you bring your collective wisdom to the LHIN board? Is it sort of board to board? How do you work together?

Ms. Kelly Kay: In a couple of different ways: certainly at the board level, but we also work directly with LHIN staff in providing oversight to their programs and actually doing the design work.

Ms. Helena Jaczek: One of the criticisms we've heard across the province is that there's too much administration. I think it could be perceived that somehow we've got an extra layer in here between dollars and front-line staff—the work on the ground. How would you react to that?

Ms. Glenna Raymond: I think it's an opportunity to bring together consumers, users of the service, the very broad range of service providers and the LHIN all together in one forum, in one table, with a mandate to do system planning, program design, and communication and advocacy in terms of older adults. There is tremendous value in that engagement that is happening with that collective and collaborative effort. It's not just an extra layer; it is adding tremendous value in programming, in design and in decision-making.

The Chair (Mr. Ernie Hardeman): Thank you very much for the questions.

Thank you very much for your presentation. It's much appreciated.

LEEDS, GRENVILLE AND LANARK DISTRICT HEALTH UNIT

The Chair (Mr. Ernie Hardeman): Our next presenter will be the Leeds, Grenville and Lanark District Health Unit: Jennifer Labelle, public health nurse. Thank you very much for sharing your time with us this morning. As with the previous delegations, you'll have 15 minutes to make your presentation. You can use all or any of that for your presentation. In what time is left of the 15 minutes, we'll have questions and comments from the committee. With that, the clock starts now and the rest of the time is yours.

Ms. Jennifer Labelle: Thank you, Chair and committee. I'm here today to talk about my experience with the provincial Integrated Falls Prevention Framework and Toolkit of July 2011, which identified falls prevention as one of the key pan-local health integration networks' priorities in September 2010—and the ratification of it as a priority by every LHIN CEO in October 2010.

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The main objective of this document is to “improve the quality of life for Ontario seniors aged 65 years and over and lessen the burden of falls on the health care system by reducing the number and impact of falls.” The report states that “A LHIN-wide integrated falls preven-

tion program must be implemented in each LHIN catchment area.” Supporting the integrated falls prevention document, the South East LHIN acknowledged the importance of falls prevention in its Integrated Health Service Plan for 2013 to 2016, stating that it would work with public health, community care access centres and long-term-care homes to develop a regional approach to falls prevention that aligns with the provincial falls prevention tool kit.

Both documents align well with the Ontario Public Health Standards of 2008. “Public health units are required to take action to reduce falls as articulated in the public health standards.” There is an excellent match with the health units' requirement to work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs and the creation of safe and supportive environments to prevent falls in people 65 years and older and the integrated falls prevention program. It addresses the use of comprehensive health promotion approaches to increase the capacity of this population to prevent injury through collaboration with and engaging community partners, mobilizing and promoting access to community resources, providing skill-building opportunities and sharing best practices and evidence for the prevention of injury.

Public health units are experts in the application of communication and social marketing to educate the public on the issue of falls prevention, but there are challenges to reaching and influencing the intended audience. Health promotion and preventive measures mainly target healthy and low-risk seniors who may not necessarily be 65 years or older, promoting healthy lifestyles and the social determinants of health to prevent falls from occurring in the first place. The results from these interventions will not be realized for many years.

Research tell us that many older adults reject falls prevention advice because they view it as a hazard reduction, or the use of aids such as canes and walkers as a restriction on their activity or as not relevant to them because it is only necessary for older, disabled individuals. They find the messaging patronizing and a threat to their identity as well as their independence.

There is important work for health units to carry out, but the impact that can be made for individuals and the health care system is limited if we work alone. The burden to lessen the risk of falls cannot fall on the shoulders of the seniors themselves. For those with complex health issues, there is no amount of lifestyle change that can overcome the side effects of medications and declining function due to age.

With this in mind, the provincial Integrated Falls Prevention Framework and Toolkit explains the importance of ensuring that the majority of seniors aged 65 and older should be screened or assessed for risk of falls at multiple points, including self-assessments. To match appropriate interventions to individual needs, screening and assessment is the first step in determining the most appropriate individualized interventions. This crucial step

can only be achieved within the context of an integrated system to develop common screens and tools and to co-ordinate multiple partners to reach seniors at multiple points and a database of available interventions.

An essential component of the LHIN-wide integrated falls prevention program is an understanding by health care providers and caregivers of the screening, assessment, referral and treatment protocols to follow when encountering people who are at risk of falling. Working individually and in isolation, no one will have the ability to connect all the pieces that make up a program such as this. This is why a LHIN-wide intervention is so important to leverage available resources. It will take the involvement of all the relevant health care organizations at a local level, including LHIN-funded, non-LHIN-funded and private organizations. There are many falls prevention initiatives being implemented by numerous organizations; therefore, it is crucial that each LHIN-wide integrated falls prevention program is aware of such initiatives to be able to appreciate, coordinate and integrate with them.

At this time, a database of such initiatives does not exist within the South East LHIN catchment area. One way to ensure this understanding is through a LHIN-wide referral algorithm that outlines agreed-upon protocols and all the interventions available to seniors within the LHIN in which they reside. All of this must be supported with targeted education directed not only at seniors, but also formal and informal caregivers, health care providers and community members.

The catchment area of Leeds, Grenville and Lanark District Health Unit falls within two local health integration networks: the Champlain region and the South East. Understandably, there are differences in the two LHINs. The Champlain LHIN approached us in November 2012 as it prepared to move forward with its integrated falls program. The Champlain program starting operating in one geographic sub-region, and, as it expanded outwards, the people of North Grenville and Lanark started questioning why they would not have access to falls prevention programs they'd heard about in regions closer to Ottawa.

Currently, the program is set to expand into the north Lanark and North Grenville areas, where many residents, their caregivers and health care providers are anxious to have access to the services provided through the falls prevention programs. When the expansion of the Champlain LHIN reaches its borders, that is where an integrated falls prevention program will end for the people under the catchment area of the Leeds, Grenville and Lanark District Health Unit, vastly limiting falls prevention intervention for parts of the community.

In the geography serviced by the South East LHIN, there are a number of individuals and organizations who are passionate about falls prevention. Organizations such as Community and Primary Health Care and Country Roads Community Health Centre are doing great work, such as providing exercise classes. As spelled out in the provincial Integrated Falls Prevention Framework, their

ability to have an impact on the number of people suffering falls is greatly diminished with the lack of coordination and integration.

The health units of the South East LHIN—Leeds, Grenville and Lanark; Kingston, Frontenac, Lennox and Addington; and Hastings and Prince Edward counties—reached out to the South East LHIN in October 2012, hoping to initiate interest in the integrated falls prevention program. We were hoping to start with an assessment of the current falls prevention initiatives in the South East LHIN catchment area, but to date there has been no word of any progress. With new concerns, such as the changes in OHIP funding for physiotherapy exercise classes, we are concerned that the new priorities will compete with limited resources and there will never be an integrated falls prevention program in the region.

As part of the health unit's accountability agreement with the Ministry of Health and Long-Term Care, the Leeds, Grenville and Lanark District Health Unit will continue to monitor the rates of injuries related to falls that result in emergency visits in adults aged 65 years and older. It is foreseeable that the change will not be favourable for regions that will see no change in current interventions.

An additional concern is that if there's no LHIN-wide integration plan in place for the South East, the population will not be able to benefit from any provincial structure that may be created in the future. This lack of progress in implementing a LHIN-wide program will affect the quality of life for many seniors, as well as have a negative impact on health care in general and the costs associated with it. It's imperative to do more than to write about frameworks and tool kits for falls prevention. The programs must be developed and implemented.

As public health nurse practitioners, we are guided by the Ontario Public Health Standards. One of the requirements is to influence development and implementation of healthy policy and programs and the creation or enhancement of safe and supportive environments that address falls across a lifespan, including falls in people 65 years and older.

As a public health professional, I would advocate not only for the writing of the documents, such as the provincial Integrated Falls Prevention Framework and Toolkit, but the development and implementation of the falls programs for all citizens of Leeds, Grenville and Lanark. By presenting today, I'm hoping to encourage the implementation of the initiatives reported in the falls prevention document.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have six minutes left, so we'll have two minutes from each party, starting with Ms. Gélinas.

M^{me} France Gélinas: This is really unbelievable, because we started the day being told that the South East LHIN had the highest population of people 65 and over. They described the region as being really focused on the needs of the elderly population, yet the South East LHIN did not implement the falls prevention, and the Central

East, that never presented to us for their high population of 65 and over, did. This is what you told us.

Ms. Jennifer Labelle: This has been my experience so far.

M^{me} France Gélinas: All right. We're here to look at the LHINs. Did you do things differently with Champlain than the South East that could lead to those different results?

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Ms. Jennifer Labelle: I did not do anything with the Champlain. They came in and invited us in. They've been quite open. They've been inviting us to any workshops, any programs that have been going on. They've been open about anything they've been doing. And even before they started expanding into our area, they came to us to invite us into that network.

M^{me} France Gélinas: The same thing did not happen with the South East?

Ms. Jennifer Labelle: In the South East, we contacted the LHIN, hoping to have a meeting. We had one meeting, and there was supposed to be a follow-up meeting in a few months. The person we had contact with—we're not sure what happened. That person is not there anymore, and there was no more contact. When we tried again, it was difficult to find who was responsible for this area.

M^{me} France Gélinas: Is this typical of health unit programs—

The Chair (Mr. Ernie Hardeman): Thank you. Next? Um, Ms. Jaczek.

Ms. Helena Jaczek: You should know me by now, Ernie. We've spent the last eight days together.

The Chair (Mr. Ernie Hardeman): It just got me so frustrated—flustered.

Ms. Helena Jaczek: Thank you so much. It's great to see a public health professional here. As a former medical officer of health, one of my great frustrations with the LHIN boundaries has been that they're not coincident with public health units. We've heard from many deputies that, in fact, they would like to see public health integrated within the LHIN, but given that kind of structural anomaly, that would be a major, major shift. So thank you for sharing the frustrations on the ground.

In terms of moving forward—I mean, obviously, this must be well known between the Champlain, South East and Central East—has anyone come up with solutions at the LHIN level to see how we can make sure that this important program gets disseminated?

Ms. Jennifer Labelle: We've made no headway. It's getting to be that maybe it would be better to work without the LHIN, because it's taking too much energy to be able to build those relationships.

Ms. Helena Jaczek: Okay, thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Clark.

Mr. Steve Clark: Thanks very much, Chair. Jennifer, I want to thank you for your presentation. I know you know that I share your frustration. I have to say something nice: Since Donna Segal took over at the LHIN, at

least I'm able to get regular meetings with the LHIN, which I couldn't get with Ms. Thompson in the chair.

Mr. Huras is sitting there. He knows my feelings. It drives me crazy that I have two LHINs covering my riding, and there are two different standards. Dealing with Champlain and dealing with South East can be very, very different, and I think that's a challenge. When I challenged Mr. Huras, back when I got elected in 2010, to prove to me that the services that we get in Leeds–Grenville are comparable with other LHINs, that wasn't able to be given to me, and that's something that I think is very important for a member of provincial Parliament.

When they get these examples—I've gotten this example at my office several times from the folks in North Grenville: “Why can't we have these services in Brockville?”—or Gananoque or up in Portland, for example, in the rural area in Leeds. I think this is the frustration that I have with the LHIN system: You have these inconsistencies, LHIN-wide, where you have a health unit that covers the entire riding.

I think, really, if there's one good thing that can come out of this review, it's that we need that more consistent model moved forward—especially when I read in this presentation that the LHIN CEOs agreed with a pan-LHIN model across Ontario. To me, if you're going to agree, you have to provide the proposal.

Sorry that I'm rambling on, but I do want to thank you, and if you've got any other comments, I'd love to hear them. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We didn't leave any time for that comment to be heard.

Mr. Steve Clark: Sorry.

The Chair (Mr. Ernie Hardeman): But we do thank you very much for your presentation. It's much appreciated.

PATRONS OF OUR COUNTY HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presenter is Patrons of Our County Hospital: Betsy Sinclair, vice-chair; Jane Wallenberg, secretary-treasurer; and Ian Batt, member.

As you're getting seated, thank you very much for joining us this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end, we will have questions and comments from the committee. That's not necessarily a prerequisite. With that, we start the clock, and it's your 15 minutes.

Mr. Ian Batt: Thank you, Mr. Hardeman. Good morning, ladies and gentlemen. My name is Ian Batt, and I belong to a group called Patrons of Our County Hospital, or POOCH for short.

We are a community-based group of volunteers whose mission is to ensure the proper stewardship of the only hospital in rural Prince Edward county; namely, Prince Edward County Memorial.

In 1999, the Honourable Allan Rock said, “We can never accept the notion of limited access to health care for the one third of Canadians who live in rural and remote Canada. Geography cannot become an excuse for inequality.”

While the challenges to the health care system are great, we hope our presentation today will cause you to address a continuing and singular lack of stewardship and response by the provincial government and its local bureaucrats to the voices of the residents and stakeholders of our county hospital.

Briefly stated, since 1998 our hospital has been subjected to a disproportionate number of cuts to acute-care beds, hospital services, nursing staff and support workers. The vast majority of these services have been relocated to Belleville General Hospital, and more are anticipated this fiscal year.

The South East LHIN is complicit in these reductions. The local health integration network act of 2006 requires the LHIN “to set up requirements for community engagement” while, at the same time, “it requires service providers to comply with LHIN decisions on integrating services.” If that’s not enough clout, the act “provides the minister with the power to integrate service providers in certain situations.” Where is the participatory democracy in this structure?

We are calling on this committee to take action to accomplish the following: Reboot the LHINs—and the word “boot” is maybe appropriate—to clearly become the stewardship-oriented entity that they were reconfirmed to be by the provincial government in 2006. How?

Some highlights would include appointing a broadly based panel of elected municipal and provincial representatives and local doctors to report within six months to the cabinet with recommendations related to:

- reviewing the LHIN model and its functionality, particularly as it relates to its stewardship role;

- considering the implementation of a fully transparent and open process within all LHINs and their individual hospitals, including, but not limited to, planning, finance and administration;

- contemplating the thought that bonuses are not automatically paid for just doing the job or retiring on time;

- reviewing the benefit of putting all privatization opportunities through an independent vetting process, with the final say resting with the minister; and

- appointing a LHIN-focused ombudsperson with teeth.

Frankly, we lay all our issues and disappointments at the feet of the LHINs’ masters. It is the provincial government which needs to give stewardship and transparency their rightful place in Ontario’s health care system.

Thank you for your courtesy.

Ms. Betsy Sinclair: Good morning. My name is Betsy Sinclair.

By the spring of 2013, with more Prince Edward county hospital cuts on the way—politically referred to as service integration—most of the residents of Prince

Edward county were fed up. Four busloads of ordinary citizens carrying a petition with well over 5,000 signatures headed to Toronto to meet with the minister, Deb Matthews.

The infamous letter from her that arrived in June basically said no to de-amalgamation and, in future, to get approval from Quinte Health Care and the South East LHIN before coming again.

Have no doubt: The LHIN is a corporate animal which, by its very nature and legislation, requires all to submit to its programs and initiatives, regardless of the human fallout.

In October 2013, POOCH became aware of a document entitled Local Health Hubs for Rural and Northern Communities, sponsored by the Ministry of Health. As per the minister’s instructions, we approached Quinte Health Care. POOCH was supportive of the document because it contained new and innovative approaches to rural communities that the present system simply ignored. Was it perfect? No, but it certainly went a long way to improving relationships and issues of local governance which we believe any government must be sensitive to in dealing with a rural community.

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To our astonishment, we were informed that Prince Edward County Memorial Hospital is not a rural hospital; it is a “small” hospital. Prince Edward county is an agricultural, tourist-based, rural island economy, and we fit the definition of a rural hospital as outlined in the Hub document. Change a word and you change the outcome. Prince Edward County Memorial Hospital has been excluded from participation. In communications regarding “small” versus “rural,” Quinte Health Care indicated that their decision to have Prince Edward County Memorial Hospital declared “small” versus “rural” was based on the 2006 Core Service Role of Small Hospitals document and the Hub document of 2012. We have these documents. “Small” refers to the number of weighted cases and does not exclude the use of the term “rural,” which by definition is a geographic term. Prince Edward County Memorial Hospital has always been a small, rural, B2 hospital.

Further investigation indicated that Quinte Health Care, in April 2013, used both these sources for a motion at their board meeting to determine the future of the four Quinte Health Care hospitals. One has to ask why, if they had most of this information in 2006, they waited seven years to act on it. If one had a suspicious nature, one might conclude that with the publication of the Hub document imminent, they preferred a pre-emptive strike against any possibility of discussion or actions by the citizens of Prince Edward county.

Again, in the spring of 2013, Prince Edward County Memorial Hospital was refused funding while Bancroft, also a small rural hospital in Quinte Health Care, got \$488,000. LHIN CEO Mr. Paul Huras indicated to the press that he would look into the matter. To date, we have had no update on his inquiries. As one hospital supporter remarked in the press, “What this really is, is

punishment for wanting to break away from Quinte Health Care. Read between the lines, everyone.”

It is interesting to note that Mr. Paul Huras, on December 5, 2013, received an invitation by phone to participate on the Multi Sector Rural Health Hub Advisory Committee.

Ministry directive or not, the South East LHIN will be hearing from us.

Thank you for your attention.

Ms. Jane Wallenberg: Good morning. My name is Jane Wallenberg, and I’m also a member of POOCH. Unlike other members who have lived in the community for many years, I moved here quite recently from Saskatchewan, where people pay very, very close attention to health care matters.

What I’ve learned in the years that I’ve been away is that, in many ways, particularly in the rural parts of Ontario, it has not offered better and more innovative health care to its citizens; in fact, it has become excessively and insensitively bureaucratic. The people who know what’s required in their communities, especially rural communities—i.e. the primary health care providers and those who need their services, the patients—have been ignored and in some cases disparaged.

These failings can be partly attributed to the federal and provincial governments for not providing stable, appropriate and adequate funding, as well as, in our case, the South East LHIN and QHC, who are especially complicit in this. Instead, the LHIN prevents the people who live locally and who are considered better able to plan, fund and integrate health care services in their own communities from doing just this, as it’s stated in their purpose on their website. Rather, they have continued to issue short-sighted, ill-advised cuts, without providing the leadership and consultation required to address the gaps these cuts have caused. This is the crucial message: We can’t sustain ourselves by fundraising and by volunteers alone.

The level of interest, knowledge and commitment this community has demonstrated over the past 18 months, not to mention since the early 1990s when the changes began in earnest, is formidable. In partnership with the family health team, Prince Edward County Memorial Hospital and many other local and province-wide groups, we, the citizens of the county, have made known our dissatisfaction with the continuous cuts to our hospital and the clear expectations for the levels of health care we require. But we aren’t being heard.

I’m speaking for real people, seniors like my parents and others like them in our community who deserve to be treated with respect and receive the excellent health care that is possible if the right plans are put in place. It’s also the elderly person, alone and disoriented, having been transferred by taxi from Picton for an appointment with a specialist now in Belleville that should have been available to him or to her in their own town, and that was, actually.

It is the senior desperately trying to maintain his or her independence with dignity, living alone with limited

support in an apartment and not wanting to bother anyone regardless of the pain and difficulty living on their own causes them. And it’s the people in our community who are poor and struggle with mental health issues and lack basic support in their lives which contributes to their living in poor health, who are just some of the victims of these short-sighted cuts. They need and deserve accessible, good health care and home care services in their own communities. Providing it not only makes sense, but it’s also less costly.

According to the JPPC Multi-Site/Small Hospital Advisory Group in 2006, increasingly “place” is becoming identified as a determinant of health because people in predominantly rural regions have a lower life expectancy than the average Canadian; disability rates are higher in smaller communities; there’s an increased prevalence of chronic disease in smaller communities; “place” particularly affects the health of the elderly; and there are fewer available community supports.

These are just a few of the challenges we and so many other rural communities face each and every day. We are offering you an opportunity to help us create community health care that’s inclusive, effective and compassionate. Some of the frailer and weaker voices may not be able to sustain the fight, but we can and we will. We will not go away, and we would rather work with you to promote and insist that the agencies controlling health care funding and allocation make the changes that are necessary for our communities to live and continue to grow and prosper healthily. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you all for the presentation.

We have just over three minutes left so we will just go to one party, the third party.

Before we do, I’ll just take a moment. I want to say that in the first presentation—appointing a committee to review the operation of the LHIN, that is why we’re here today.

Mr. Ian Batt: Okay.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Gélinas?

M^{me} France Gélinas: We both represent northern, small, rural communities and we live your pain each and every day. The policy coming from the Ministry of Health is to make small hospitals self-implode. They’re not allowed to do baby deliveries anymore because they don’t do enough. They’re not allowed to do hips and knees because they don’t do them as cheaply as the University Health Network. They’re not allowed to do this, that and the other thing. Then they can’t recruit, can’t retain and they self-implode. You go to your LHIN and the LHIN doesn’t listen.

We need good policy to make sure that northern, rural, remote, small—call them whatever you want—hospitals have a way to continue to serve the community that they were there to serve. This has not been happening.

The fact that you have tried to go to your LHIN and have not been heard is very disappointing but not that surprising. I have very little to offer to you. I’m not going

to give you false hope. We are here to review the LHINs. What you have said to us is really that you want some kind of a review process. You want to make sure that the LHIN not only takes the time and has the courtesy to listen to you, but actually acts upon what you have said, and none of this has happened.

The first thing that comes to mind is some kind of a process to review those decisions. I don't know if that would help. How would you like it to change?

Mr. Ian Batt: I think that just an open conversation—unfortunately, the leadership at the LHIN is not well liked. The doctors, for instance, who I talk to in the county really have very little time for the LHIN leadership, which is an unfortunate start to the whole conversation. There's just a total general attitude of negativity, just for starters. I think that was why we put in the thought about the ombudsperson because there are examples of good, local ombudsmen in Ontario, André Marin being one.

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The Chair (Mr. Ernie Hardeman): Thank you very much, but that's the end of that 15 minutes that I talked about.

Thank you very much for your presentation and bringing your concerns here. As I said earlier, it is part of what we're trying to accomplish through this committee.

OPSEU REGION 4

The Chair (Mr. Ernie Hardeman): Our next presentation is OPSEU Region 4: Dan Anderson, local president, and Hervé—

Mr. Hervé Cavanagh: Cavanagh.

The Chair (Mr. Ernie Hardeman): —Cavanagh, local president, yes. I don't know why it wouldn't come to me.

Welcome. We thank you for coming in and sharing your time with us this morning. As with previous delegations, you'll have 15 minutes to make your presentation. You can use all or part of it for your presentation. If there's any time left at the end, we'll have comments and questions from the committee relating to your presentation. With that, the 15 minutes start now. Thank you very much for coming.

Mr. Dan Anderson: Thank you very much for listening to us. Hello. My name is Dan Anderson. I'm currently the president of Local 431 OPSEU, which serves over 500 members working at Providence Care Mental Health Services. I am also a registered practical nurse at MHS, with over 40 years' experience in the mental health field.

I am here today to voice my and our members' concerns surrounding the LHINs' direction in mental health care. We as mental health providers have little to no voice to the bed cuts, staffing and placement of clients. We strongly believe that we can be part of the solution to providing the excellent care that the clients deserve and their families expect.

In the last couple of years we have seen a dramatic cut in mental health beds and reduction of staff in both outpatients and within the facilities. Our community has lost experienced and dedicated nurses and other mental health workers due to these cuts. Last October, in 2013, Providence Care Mental Health Services saw over \$6 million cut out of their budget. Did that money go all back to outpatient services?

When asked why we are cutting beds and budgets, the answer always provided to the workers comes back to an outdated report of the Health Services Restructuring Commission. The data on which that report is based go back to the early 1990s. Things have changed. One of them is the closure of mentally delayed facilities like Rideau Regional. MHS now deals with these clients, who are aggressive and can't function in the community. This has further reduced mental health beds.

Why are the LHINs not having open meetings with the workers to get the ground-level view? Is that not why the LHINs are there—to make sure that the best possible care is provided to the citizens of this area?

One of the most glaring aspects of the change in mental health in the Kingston area is the fragmentation of services. You have two hospitals providing in-patient services. Outpatient services are provided by two: Providence Care and Frontenac Community Mental Health Services. On top of this you have funding for other mental health teams, such as Behavioural Supports Ontario and ACTT teams.

The more fragmentation, the more management and administrative supports are required. Considering the much higher level of compensation for these managers, it means less money for the front-line services. It makes you think: Are these services there to support managers or the mentally ill?

Placement of clients in long-term facilities in the community has to be the right fit. Mental health clients with aggression or other cognitive issues are rarely the right fit unless properly trained staff exist. As well, these clients require more nursing hours due to their illness. The staff in nursing homes—mostly PSWs—have little experience with these aggressive clients and their behaviours.

Understaffing in long-term-care facilities is common due to the funding formulas. A recent article from the Toronto Star highlights the crisis in our long-term-care facilities—and a plea from the 630 facilities that are under the Long Term Care Association and Association of Non-Profit Homes and Services for Seniors for more money to help train staff and hire more workers.

The care of aggressive elderly clients was part of the business of mental health services, formerly the Kingston Psychiatric Hospital and other hospitals, where you had trained staff and the experts. Is it really better to spread the problems from several facilities out to 630 facilities? Who does this really benefit? With the rush of the baby boomers in the next couple of decades, is this the right approach to meet their needs?

Clients in the community need more supports to be successful and productive in their community. Unfortunately, many more chronically mentally ill fall through the cracks, because beds are being closed and they're told that they can't get back into hospital.

If a client goes to KGH, they may face a six-to-eight-hour wait to be seen. This is usually unbearable to most schizophrenics and others, therefore they often don't get seen. Because of the deterioration of their mental state, some act out and end up in the court system or turn to illicit drugs. Some fall through the cracks and end up on the streets.

Respectfully, the system is broken. It does not fully serve the needs of our clients. I've talked with many psychiatrists, GPs and other health care professionals within and outside this province. We do not fully agree with the direction of the mental health care that is being provided in Ontario, but we do believe that the system can improve when the LHINs can work collectively with direct-care workers and reduce the fragmentation of the services.

Each LHIN is to be accountable to the communities that they serve. When can we have meaningful dialogue?

Mr. Hervé Cavanagh: Thank you, Dan.

My name is Hervé Cavanagh. I'm a resident of Tay Valley Township, and I've been a physiotherapist for 22 years now. I've worked both in the public and the private sectors; I've worked both in Canada and the United States in my profession. I'm also the president of OPSEU Local 466, which represents the hospital professionals at our local hospital in Perth and Smiths Falls, and also the support staff at the local retirement home in Carleton Place.

When it comes to hospitals, our residents are very sick, particularly in Lanark county, which has a high proportion of retired people, most of them in rural communities. If we look at Lanark county, we have three major communities: Perth, Smiths Falls and Carleton Place. All of them have a population under 10,000 people. We're the only hospital north of the 401 in the South East LHIN. The population has a higher need of health care and hospital resources, particularly for the stroke and the fracture patients. Those are the diseases of the elderly. It's in the industrialized countries that we see people falling because we live longer; we fall and we break our hips. We live longer, we have strokes. We live longer, we have congestive heart failure. This is what we see in our county.

It is important and crucial that we identify these risks that the people are facing, and this is what we see when we see these people in the hospital. For example, a patient suffering from congestive heart failure is at risk of losing 30% of their functional ability during a hospital admission. By taking away access to rehab services, the impact on mobility is extremely negative, only to increase the length of stay as a result.

However, rehab can be used to improve patient flow and outcomes. By providing early access to physiotherapy, occupational therapy and speech therapy, we can

improve patient flow; maximize quality outcomes, which helps to reduce unnecessary readmission; and we can reduce health care spending. Let's face it: Therapy is cheap and the length of stay in hospital is not. When we look at stroke care, for every dollar that we invest in in-patient rehab, we save \$4 in other hospital costs.

According to the magazine *Physiotherapy Today*, proper investment in rehab can reduce at least \$20 million a year in the Ontario system. But for achieving these savings, we must provide rehab care to the patient as soon as possible once they are admitted in hospital. This is what we call "front loading" of rehab care.

The best practice guidelines provided by the stroke strategy of eastern Ontario recommends a minimum of three hours a day of therapy, seven days a week. We still run a hospital like a business, five days a week. When we're sick, we're sick on weekends; we're sick on weekdays.

This is a crucial time for stroke patients to benefit from rehab. When forced to wait for a long period of time, their brain begins to shrink and rapidly leads to atrophy of neural tissue, which reduces the potential of their recovery. But when you provide rehab services early after their admission, the brain tissue is known for recovering faster and even expands, facilitating the learning of new motor skills and therefore improving their mobility.

However, what I see in Ontario is going in the wrong direction. I'm concerned about the rehab services. In the last three years, at least 50% of hospitals have reduced physiotherapy and rehab services. This is happening without consultation. It has happened in Perth and Smiths Falls as well. Due to financial compression, we faced a reduction of 3.1 full-time equivalent in physiotherapy in the last budget in the Perth and Smiths Falls hospitals. Over the years, I've faced at least a loss of one full-time equivalent for occupational therapy and a 0.5 position for speech language pathologists. We're saying that if we invest in these professions, we can save money down the road, but we're taking them away, lengthening the length of stay in the hospital. This is happening, again, without consultation.

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With the rising costs of hydro and postage alone in the near future—our hospital is facing a freeze in their budget for the next four years, so am I to expect that physiotherapy and rehab services will be on the chopping block because we can't afford to pay for hydro, because we're not a priority—our services? Again, am I a scapegoat, just to say, "Okay, physio, you're out the door. We don't have the money anymore." Are we doing a favour to our residents in Lanark county? Have we been consulted on this issue?

It comes down basically to, when we have a patient who has either a stroke, a fractured hip or any other medical condition, if we deny them the service that they need, I think that's unethical. We have a responsibility to face. Let's face it together. We can bring solutions together.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We have about four and a half minutes, so we will have it go around. First is the government side: one minute and a quarter. Mr. Flynn.

Mr. Kevin Daniel Flynn: One minute and a quarter; okay, I'll make this quick. I'm from Oakville. We're from a different LHIN, obviously. The experience that I've had, particularly in the mental health field, has been almost the opposite to what you just outlined. We had very few services in our community. The LHIN became involved, and our services have improved tremendously over the past few years and continue to improve. The LHIN has become a very strong advocate for the local hospitals as well. They seem to go to bat for them.

You seem to be telling a different story. Is there a communications link missing? Have you spoken to the LHINs? Have you sent them information as to how it should work?

Mr. Dan Anderson: We've gone through our administration, requesting to speak with the LHINs, and we've not gotten any response.

As staff members, and also as the union president, we get very little information from the LHINs, and also from management, as to what the plans are until the last minute.

I can cite, as an example, the last cut that we had, part of the \$6-million cut. We asked a year—

The Chair (Mr. Ernie Hardeman): I do have to stop it there. As I said, it's a very short time for each party.

Mr. Clark.

Mr. Steve Clark: Thanks very much for your presentation. I agree that consultation is pretty key, and I appreciate your frustration in not being involved in the process. Some of the ideas and suggestions you have, I think, are very valid and should be taken into consideration by the LHIN when making those service decisions.

The mental health piece is very important to me as well. We had a bit of a situation in my riding where we had the Champlain LHIN funding a mental health—the Brockville Mental Health Centre was like an island in Leeds—Grenville, so it was a bit of an anomaly.

You did talk about the piece of coordination. Is that another pretty key piece, seeing what's going on in Kingston with Providence and some of the other decisions? Could the system be coordinated better?

The Chair (Mr. Ernie Hardeman): If you want to give him time to answer, you're going to have to cut your question to the right length.

Mr. Steve Clark: I'm shutting up. I'll be quiet; I'm done.

Mr. Dan Anderson: Yes, part of it is coordination. For us, it's very much that we feel we can provide services. Most of the staff at my facility have in excess of 25 years' service—or did. We feel we can contribute. We believe in community services. The problem is that we're not getting opportunities to go out into the community, other than through our own ACT teams. Geriatrics is a

fine example: We're finding, with nursing homes, that they have the BSO teams, but they're mostly provided by PSWs—

The Chair (Mr. Ernie Hardeman): Okay, we're going to have to cut it off there.

Ms. Gélinas.

M^{me} France Gélinas: As president of your local, have you ever been invited by the LHINs to come and talk to them?

Mr. Dan Anderson: Never.

Mr. Hervé Cavanagh: Me neither.

M^{me} France Gélinas: Have you ever reached out to the LHINs, on behalf of your membership, to say that you have something to contribute?

Mr. Dan Anderson: Through our management, we did.

Mr. Hervé Cavanagh: We've reached out to our local MP without success, and we reached out to the community, which raised a lot of meetings and stuff like that. But with the LHIN, being an employee of the hospital, I have to be careful when I go and I try to speak on behalf of a union for obvious reasons.

M^{me} France Gélinas: I can tell you that other LHINs do invite their unions, they do talk to the union membership, and there is a wealth of knowledge. You live in your community. You are a resident of your community. You need care just like every other human being, and you have something to say. There is no reason for your LHINs to deny you—not listening to you. Can you think of why?

Mr. Hervé Cavanagh: I don't think they're interested to hear what we want. What we want is to reinvest in the service again.

My impression with the LHIN so far—every time I talk through my managers in either an FAC management or a labour management committee, they tell us, "We don't have the money, and we need to rationalize what we need to do." So, again, we've been under pressure to squeeze services out.

The Chair (Mr. Ernie Hardeman): With that, thank you very much. Thank you very much for your presentation. That does conclude the time. We thank you very much for taking it.

That concludes our morning session. A couple of announcements: The committee will have lunch served in the Martello Room.

This afternoon, we have a unique experience: We have a substitution. At 1:45, the Mental Health Support Network South East Ontario will be making a presentation, instead of the one that's on your agenda. Just exchange the one.

With that, lunch.

The committee recessed from 1205 to 1259.

The Chair (Mr. Ernie Hardeman): We'll call the committee back to order. I hope everybody enjoyed their lunch and the break.

CANADIAN HEARING SOCIETY

The Chair (Mr. Ernie Hardeman): Our first presenter this afternoon is the Canadian Hearing Society: Karen McDonald, vice-president of program services. She has Katherine Hum-Antonopoulos with her. We want to welcome you both here this afternoon, taking the time to come to speak to us. You will have 15 minutes to make your presentation, and you can use any or all of that time to make your presentation. When you have finished, if there's time left, we will have questions from the committee. With that, the next 15 minutes is yours.

Ms. Karen McDonald: Thank you very much for inviting me to do a presentation on behalf of the Canadian Hearing Society and on behalf of OCSA. This is a great opportunity, and I really commend the committee for doing a review of the LHIN act.

A little bit of background about CHS: CHS is a multi-service agency. We are a member of OCSA, and we are a charitable agency that's been around since 1940. We are the leading provider of products and information that remove barriers to communication, advance hearing health care and promote equity for people who are culturally deaf, oral deaf, deafened and hard of hearing.

We are unique in North America—

Interruption.

Ms. Karen McDonald: Sorry. I'm always being told that I've got a soft voice.

We are unique in North America. We provide a complete roster of services, only some of which are directly funded by the LHINs. We provide sign language interpreting services and real-time captioning, which I could have asked for today, but it can be quite intrusive for organizations that are not familiar with it, so we did not do that.

We also provide employment consulting, educational support services for post-secondary students who are studying part-time, specialized counselling services, sign language instruction, hearing tests and hearing aids, and we are the largest provider of a range of communication devices, including TTYs, visual smoke alarms and baby monitors. We are certainly very grateful for the recent amendment to the legislation which has ordered visual fire alarms to be installed in residences going forward.

We are the largest agency of its kind in Canada, and we employ approximately 450 people who deliver about 17 different programs and services through 28 offices across the province. Our national advocacy initiatives and partnerships help us to remove communication barriers and promote equity for our consumers, and our organization's communication devices program has partnered with services in Manitoba, Nova Scotia and Saskatchewan to assist them in servicing consumers in their provinces.

Now I'll just move on to talk specifically about the LHIN-funded programs. We have a range of LHIN-funded programs. We have counselling services which include our Connect mental health services, our general

support services, our hearing health care program and, in Toronto only, our audiology and oral rehab program.

The Connect mental health service provides mental health counselling, education and advocacy, and these are really for individuals who find the mainstream providers to be a barrier to them accessing it. That can be because the mainstream providers may not understand the unique cultural needs of individuals who are deaf, but it can also be because of the need for interpreting services and the costs of those. Most of our counsellors in the Connect mental health program—not all, but most of them—are either culturally deaf themselves, or if they're not, then they are fluent in sign language.

In terms of the stats, we saw 660 individual clients in 2012-13 who would fit our criteria, and we do have a number of communities in Ontario where we have significant waiting lists for this service.

Our general support services serve individuals 16 years of age and over and provide general counselling, advocacy and special assistance. You may wonder what the difference is between the two services. The main difference is that the general support services do things that you and I may take for granted. It would actually go with an individual to a bank to help them negotiate a mortgage. It might go with someone to court, if they were going to Small Claims Court, and facilitate the communication between the individual who was deaf and the service providers. The hearing care counselling program is a very unique service. We serve individuals who are 55 years of age, or younger individuals with multiple disabilities. This service is primarily given in the home, so it's counselling and assistance with communication strategies between the individual and their family or their community partners and also to assist them in accessing communication devices. These two programs are reported together to the LHINs, and we served approximately 8,000 clients last year.

Here is really the crux of our submission: CHS provides services in all 14 LHINs, but we have MSAs with 11 LHINs. We do not have contracts with the Central West or the Waterloo Wellington LHINs, and we have a service level agreement through the North Simcoe Muskoka LHIN. We also have two separate MSAs with the Central LHIN. We have two different funding models. We have a centralized funding contract, and we have regional contracts that are multiple, as I've just shown.

We think that there are many benefits to having a centralized LHIN contract. The Toronto Central LHIN, for instance, funds the Connect mental health program through the lead LHIN model, and this is very beneficial to CHS and, ultimately and most importantly, to our consumers. It allows us to have one contract. There's one set of targets, and there's one set of indicators. It gives us great flexibility to either add or reduce staffing in specific regions as the needs change, because needs do change. With the regional contracts, as you'll see, that can be very problematic at times.

The challenges of the regional LHIN contracts: We have regional contracts for general support services, for the hearing care counselling program and for audiology and aural rehab. Those contracts vary tremendously in size. Some are very small, at under \$50,000, and others are very large, at over \$600,000.

The regional LHIN contracts do present some unique challenges for organizations like CHS. Each LHIN has a different board of directors, different funding priorities and different performance indicators. Put yourselves in the shoes of an agency like CHS with one head office. We are very lean and efficient, yet we're having to deal with all of these multiple different expectations. There are multiple reports that must be completed and signed off every year for each LHIN. Staff and volunteer board members are expected to attend multiple meetings in each of the LHINs.

The LHIN priorities are often competing with each other for limited staff and financial resources. For example, one LHIN mandates accreditation and only provides financial support for that region, not recognizing that financial and corporate supports are for the entire province. One LHIN mandates that CHS work towards designation status under the French Language Services Act, but CHS is not a designated agency. This is a challenging process when it only applies to one region.

The LHIN priorities are often competing with each other for limited staff and financial resources. Another, different example is that sometimes even when the priority is the same, such as health equity, the expectations of the LHINs may be different. We recently completed three different health equity surveys. They were not even remotely similar. Some mandated that they be filled out by a member of the senior management team. Others mandated that they be filled out by front-line staff. Still another expected us to have designated staff for health equity.

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I'd just like to offer some reflections on the LHINs. The LHINs are not perfect, but they have given small agencies and agencies that focus on the health and well-being of persons with disabilities a voice and a seat at the table. This is very positive and it's very important. This is the second organization that I've worked in that has had LHIN contracts; the other organization also served a very specialized population: those with aphasia. Again, it was through the LHINs that we actually were able to find a voice for those consumers. I do think the LHINs offer a very valuable resource.

CHS has been privileged to be invited to be part of the health links in a few LHINs and also to sit at a few issue-specific tables for discussion.

Dissolution of the LHINs will not immediately improve the health system and may distract from more immediate issues.

A key priority of the health system right now is to move people from hospitals to home and community. The LHINs, working with agencies such as CHS, are well-placed to make this happen. However, no base-

funding increases means that specialized agencies, again, like CHS, who do not qualify for funds designated to alleviate ALC and ER pressures, face increased costs and the pressures associated with the costs of salaries and infrastructure, and then we are in a position where we have to look at cutting services in order to maintain a balanced budget.

Under the LHIN funding mandate, budgets do not properly account for administrative costs. I'm sure that you've all heard the stories of organizations that have to keep their administrative costs to 10% or under. That is extremely challenging for an organization like CHS, where we provide services across the province. We have one centralized head office, but we actually have to charge back against the contracts and services of head office.

Provincial agencies like CHS that receive a significant amount of funding from the LHIN are well-positioned to improve efficiency within the LHIN because we already have back office integration. That's a battle that we are constantly fighting with the LHINs. They're constantly coming to us and saying, "We need you to go forward with back office integration with other agencies"—we've already got it—and making that case over and over.

We can address issues systematically across the province. We know the needs of the people that we serve throughout the province.

Finally, we have three key recommendations. Provincial agencies should be given centralized contracts for all LHIN services. This will reduce duplication and improve efficiency by allowing agencies to utilize resources across all regions. It also allows agencies to meet our governance requirements, and I can speak more to that in the question-and-answer session, if you would like.

We also recommend a coordinated approach to implementing LHIN initiatives across the province so that provincial agencies don't have to manage competing priorities with limited resources.

Third is sufficient investment in the CSS sector, which, as you know, is a very important and growing sector in this province, to ensure that community needs will be addressed well into the future.

Finally, I just want to thank you for giving me the opportunity to appear at the standing committee on behalf of both CHS and OCSA.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have one minute left. The government has the question. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much. Thank you for coming and educating us and sharing your frustrations. Have you brought this to the attention of the ministry through the years—in other words, the idea of having one centralized contract?

Ms. Karen McDonald: Yes, we have.

Ms. Helena Jaczek: And what response have you received?

Ms. Karen McDonald: Wonderful. They've been very supportive. I think the issue, as it was explained to me, really is that there's so much reorganization going on

at the ministry right now that they didn't feel that the business operation unit could take it on at that time.

Ms. Helena Jaczek: But they flagged it as something—

Ms. Karen McDonald: That they agreed with, yes.

Ms. Helena Jaczek: —that conceptually was the right thing to do.

Ms. Karen McDonald: Yes.

Ms. Helena Jaczek: Okay. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

MR. DUNCAN MEIKLE

The Chair (Mr. Ernie Hardeman): Our next presenter is Duncan Meikle.

Mr. Duncan Meikle: Congratulations. You got it right.

The Chair (Mr. Ernie Hardeman): There you go. I take the compliment. I'm not right on all of them, so the rare time that I do get it right—

Mr. Duncan Meikle: You must have been influenced by a Scot somewhere along the line.

The Chair (Mr. Ernie Hardeman): It could be. We thank you very much for being here to make a presentation. You will have 15 minutes to make your presentation. If you leave any time at the end of the presentation, we will have questions and comments from our committee members. With that, the next 15 minutes are yours, sir.

Mr. Duncan Meikle: Everybody should have a package of about 20 pages. I started to number them. Some of the pages got away, and I had to revise the numbering system, and then I had to revise it again, and then I had to put in a letter that I had somehow missed. My filing system is not what it should be.

I depend on community home support for a lot of things, particularly a drive to a doctor. The drive from my home to the doctor was, for a year and a half, \$100. Suddenly it was changed to \$116. I'm not complaining about the \$16. I am complaining about the way I was treated after I started to ask, "How come?"

I asked, "Why?" and I got three or four different answers: a normal increase in fees; I went to the far side of Ottawa; I made extra stops—and one that was sent in a mumble; I don't know exactly whether it was a reason or not.

The second, that I went to the far side of Ottawa, was false.

Extra stops: There seems to be a fair number of choices: two extra stops, three extra stops, four extra stops. At one point, the four extra stops involved being let off at the bank, and then I would go to the pharmacy, the drugstore—sorry—lawyer, post office and grocery store. We negotiated what time to meet at the grocery store. That has worked fine. All of a sudden, I was charged for four stops: pharmacy, lawyer, drugstore, post office and so on. I don't understand that.

I asked three different people, "Who is in charge?" I got three different names. These are people in the organization; I didn't ask strangers on the street corner. I asked people who were there in the office, "Who's in charge?" It strikes me as odd that any organization of any size or importance would not know who's in charge.

So to get attention, I ignored the next two bills that came in. It worked: I got attention. It resulted in a meeting between two of the personnel and myself. It was a fairly long meeting. They agreed to withdraw the \$16; that was minor. But what I insisted on was that I would pay in installments if they provided me with a set of rules.

1320

If you turn to the back of that package, you will see some examples of the questions that I asked regarding the rules: page 11 and page 12, to the community home support leader; an organization chart for the Ontario health system—for a certain distance, and then it stopped—and the letter to Randy Hillier, my MPP, asking: To whom are these people accountable? How is the LHIN funded? How much comes from the provincial government? Can you provide a breakdown? What screening tests are made of volunteers? What agencies are part of the network? How many of these are available in Lanark county? And where can I get a copy of the annual report or its equivalent? No answer. That was in September.

I keep wondering: Is somebody trying to hide something? Or are you all flying upside down, like the song at camp—"Up in the air, Junior Birdmen, / Up in the air, upside down"? I don't know, and I'm intelligent enough to follow an answer. But I don't know your system.

I think something is wrong—I don't know what; I don't know where. But when people give contradictory answers or when they give false answers, such as the letter labelled number 3—"I am writing in response to your concerns about the transportation service...." I'm not complaining about the transportation service. If I was, I would say so. It's at about the middle: I'm complaining about the way I was treated when I asked a question.

"Both my staff and Paul Huras ... have asked you to contact me directly...." The staff didn't; Paul Huras did, but only under a little bit of pressure. "You have ignored these requests"—that's not true; I went to a meeting, as requested—"and have continued to call and attempt to intimidate the agency staff."

"Intimidate"? I'm a little bunny rabbit. I don't know what's going on. I am not likely to intimidate the people who are providing transportation that I need. Personally, I'm wondering about a libel suit.

"[Y]ou have claimed not to know the 'rules'...." Paul Huras made a similar statement. The rules were never given to me when I went and said, "I need transportation." I was handed transportation in a basket: "Phone here. We will arrange it. Say where you want to go and when," etc. I was never given a set of rules. The rules that did come eventually—on pages 5 and 6: "Be dealt with in a courteous and respectful manner"—that's not a

rule; that's a value. If you want an example of the use of the word "value," turn over to page 7. A blurb from the Perth hospital: "Our Values ... where everyone is treated with dignity, respect and compassion." That's a value; it's not a rule. It's not a statement as to when the mileage begins and when it stops. It's not a statement as to how they measure mileage. Something that came up only a couple of weeks ago, after all of this was written: Mileage in some cases is measured from city boundary to city boundary. I've never heard of that one, but I present it as a possibility. I don't know how mileage is calculated.

I wrote back to the person who sent me this and said that it appears "that you have violated items one, four, seven and eight," most of which deal with financial abuse, receiving information and recommending changes without fear of interference or reprisal.

After several letters back and forth, I was cut off transportation. One of the reasons was that I was a threat to the volunteer drivers. I don't know where that comes from. I honestly don't know what's going on. When I saw the ad that this commission would be here, I said, "Fine. I will come and make a noise."

There are many errors in the letters sent to me. Nobody has pointed out an error in a letter that I sent.

The file is not complete, because my filing system is atrocious. But I urge you to pass this on to those who are not here to read it carefully and consider what \$16 can do to your organization. I'm quite willing and quite capable of paying the \$16 and the outstanding fee, but I want to know what the rules are.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much for the presentation. I think you are right. First of all, we will make sure it's passed on, and I wouldn't be surprised if the presentation, as you presented it to the committee, was likely heard by some of the people who would be involved with it. Maybe we could all get together and come up with some answers to your questions.

Mr. Duncan Meikle: Oh, boy. That'll be good.

The Chair (Mr. Ernie Hardeman): Well, I really hope that—obviously, our committee is not in the position to be able to deal with the directors. We are not the providers.

Mr. Duncan Meikle: No, but I don't know where to write. You do.

The Chair (Mr. Ernie Hardeman): Very good. And that's why we hope that we can get that message out. I'm sure some of the people who are involved in this are here for the same purpose we all are today: to hear about how the system works. Hopefully yours can be dealt with by the appropriate authorities to satisfy your needs. It seems—

Mr. Duncan Meikle: Well, I think I've shown how the system does not work.

The Chair (Mr. Ernie Hardeman): To get people to understand what the rules are shouldn't be that difficult.

Mr. Duncan Meikle: It shouldn't.

The Chair (Mr. Ernie Hardeman): No. And so, I do thank you for coming in and bringing it forward, and

hopefully your presentation here this afternoon will have an impact on getting your problem solved.

Mr. Duncan Meikle: You're repeating yourself.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here.

CARP, AJAX-PICKERING CHAPTER

The Chair (Mr. Ernie Hardeman): Our next presenter—where's my list? There it is. The Ajax-Pickering CARP chapter: Randy Filinski, consumer advocate—

Mr. Randy Filinski: Filinski.

1330

The Chair (Mr. Ernie Hardeman): Yes, you say it so much nicer than I do—and vice-president, program services. Thanks, Randy. As with all the delegations, you'll have 15 minutes in which to make your presentation—

Mr. Randy Filinski: He's just hooking me up.

The Chair (Mr. Ernie Hardeman): That's just fine. I will give you the instructions. You'll have 15 minutes to use as you see fit. You can use all or part of it. If there's any time left, we'll have questions from our committee. The clock starts when I push the button, which will be when you're ready. We won't let technology take away from your time.

Mr. Randy Filinski: Thank you very much. My name is Randy Filinski. I'm here, really, for two reasons. One is that, hopefully, I'm the proverbial consumer/patient/caregiver/resident—any name you want to put on me. I live in Pickering, Ontario. I happen to fall within the boundaries of the Central East LHIN. I've put the CARP message here because I'm going to transition my comments from "I," as an individual, to "we," and CARP is just one example of "we," being the community.

In focusing on the legislation, I really am here today to tell you about my activity, and then about "we," as a group, our activity pre-LHIN, so since I got involved in health care and then with the LHIN up until today, even, and the work that we've done, and, hopefully, give you a consumer view, a patient view, of the importance of the LHIN, and some suggestions on improving a lot of what you've heard today about what the LHIN can do.

Let me just click over here and hope this works.

Why me? I've sort of said it—if you jump to the bottom—I have 62 years of experience in health care. I was born in the Central East LHIN; I live in the Central East LHIN. I've travelled around the world, but I am a resident. I've also been a patient in the hospitals. I work with community care. I've got a family; they were born into the health system. People usually knock me, saying, "Well, you're not a service provider or a health service expert," but I am an expert, and you are experts once you step out of your job too. We have experience in health care. The consumer voice needs to be very strong.

Some of the other background here: I retired from IBM early, early, early, thank goodness. It was a great job, but I've become a professional volunteer, working with—although they're not up here—about 10 to 12

organizations in health care. I will admit, it started off with a local mayor tapping me, saying, “Could you go talk to VON? They need some help with their marketing plan and strategic plan,” early in the year 2000. That led to becoming a friendly visitor, a transportation driver for the—similar to the gentleman who just left—volunteering with the Special Olympics—just a whole rack of things, but health care became my intellectual capital. It’s the thing that I’ve examined, looked at—the LHIN tells me I’m a consumer expert—but from a consumer point of view. This is only important for the next little bit of the presentation, not necessarily for me in itself.

Now, I did say “I.” When I first started getting into health care—and if you just read some of the key words down here, I’ll make a couple of points.

It was about me, “I,” my family. Everything we did was anecdotal. If I had a problem, I wrote a letter to the ministry. I didn’t know what a district health council was. I knew who my MPP was. I knew that health was a provincial issue. But it was very, very reactive. I’d write my letters to the ministry. I’ll be very frank with you: Most times I didn’t get a letter back. I got a form letter saying, “Go to this website; thank you,” but no real dialogue, no real feedback as a community member.

When I joined boards—again, this is pre-LHIN days—I would be representative of an organization. As a board member, we would do the same thing: We’d try and look at—but in cases, they were still anecdotal. They were Mrs. Smith had a story, so-and-so had a story, and we’d try and present those coming forward—again, very reactive, and usually because you were personally involved—

Interjection.

Mr. Randy Filinski: Too close?

Mr. Christopher Beesley: Yes. It’s okay.

Mr. Randy Filinski: Can you hear that okay? Okay, sorry. I’m just excited about this.

Usually they’re very reactive stories and usually there was a personal involvement with the thing.

So as I was doing all this work with these organizations, I think it was Hugh MacLeod in Ontario who was given the mission to step back and look at what can be done in health care from a funding/planning model. Only because I was on a board did I get invited to The Barn in Markham, Ontario, where 400 service providers got together to talk about what health care was and what it could do.

Again, as a consumer—there were no consumers there. We were there as volunteers, but primarily through boards of service providers. It really twiggged my interest in health care. Following this—let me just go to the next page—the formation of the LHIN came out and it gave me the opportunity to switch from “I” to “we.”

The Central East LHIN—and I’m talking only about community engagement; I’m not here to tell you about all the things they’ve done. I’m talking about the engagement to the community, to the resident, to the patient, to the caregiver. If they’ve done a couple of things extremely well, they’ve done a job right from day one of

engaging the community, and I mean the resident and the patient. So we were invited to the table.

I happened to be on boards and moved in with this, but I found myself sitting with service providers in the community, in hospital, in long-term care, in mental health and addictions. There was never enough time that they wouldn’t ask us to come and participate in what they were thinking about and the design of enhanced services.

One of the very first things that happened was that I, representing the “we” in the groups I was with—we were invited down to Queen’s Park as consumers to meet George Smitherman or the staff who were thinking about aging at home at the time. As you probably know, it was all about community care, enhanced services, capacity building, integration etc. This was the transition point between reactive to being proactive. We had a chance to step back and talk to the community. We had a chance to gather our thoughts. We had a chance to put all the anecdotal things on the table and we soon found out they became systemic things where we could actually build a recommendation to the health care system.

At the time, what it also allowed the consumer to do, it allowed the consumer—I think, for one of the first times—to see what a health care system is.

Prior to the LHIN, health care was just a bunch of pieces. You call them silos; you call them a lot of things. At least with in the Central East LHIN, our community is seeing more end-to-end services. The gentleman who was here before me—I’m also a volunteer driver. Community Care Durham is a phenomenal community care organization with about seven to 12 different services, and through this type of action with the consumer and the patient-built services like Home First and Home at Last. That included multiple organizations coming from hospital, getting to a hospital, leaving the acute system but actually getting to the home, checking the home for safety, checking for prescriptions etc.

Again, I’ve witnessed as a consumer my reactive things to now-systemic items where I’m able to gather groups into the community and actually look and examine the health care system and make recommendations back. Again, the Central East, from day one, has had us at the table. If this was a Central East meeting, one of us from the community would be sitting out there with you participating in that review and being part of not only the listening but the design of what comes next. That’s what’s happened in the Central East LHIN.

I said I’d use CARP as an example. Well, let me come back here. The Central East LHIN is a facilitator. The best word I can give you is that they have facilitated the process. I think they recognize the value as we speak, and I know there was an RSGS presentation here earlier. There are community members on the design team redesigning those services, so specialized geriatrics are out in the community now to be in 10 community locations, including the hospitals. But as we speak, the residents are working on the redesign of those services because they’ve been invited to the table.

I probably said a lot of this: The one key point here, because I've heard this today—the other thing it's done for the consumer is it's given us this urban, rural, remote—really, a demographic positioning. When we go to these meetings, it's really relative to the local, local, local, where the people are and where they live. Again, it allows the person from Haliburton or wherever to be part of that service design. It's not Toronto or GTA saying, "This is how it should be," but it actually reflects the capabilities in and out of the areas that we're working.

CARP is just an organization. I don't want to go into it too much, but a friend of mine and myself started up a chapter three years ago in Ajax-Pickering. We've got 2,000 members. There are 4,000 members in Durham. Because of our involvement with the LHIN, we invited the LHIN in and started up a health advocacy group, and quarterly we meet with every CEO. We meet with the line staff, so the gentleman who was here from the union—we invite the union in to talk about their perspective to the community. We have a constant renewal with the community, with leaders in health care who want to come and have a dialogue. They come not to present but they come to talk, discuss, learn from the community and then feed back.

1340

Some of you may know the name Susan Eng. Everything we do in Ajax-Pickering and in Durham, we feed up to Susan Eng. We develop policies on health care, one patient brief—and obviously back to the politicians, currently Joe Dickson and—oh, heck, I can't remember. It slipped my mind. It's a senior thing here; I'm getting close to it. We feed back to the politicians and the community and up to our national organization to formulate our policy.

My recommendation is really simple: Don't stop. We've been invited in. We're at the table. We're a big component of service change, of health change. It used to be—and pardon my English—more of a bitch session. Everybody would come in with a bad story. When you come to these meetings now with the community, it's very productive: "Here are the things that are wrong, but here's the things that are working." We can name names. We see patients and we see neighbours who are delivering these enhanced services. Their quality of life and health is much better than it was two years, five years and 10 years ago.

My simple view of life is that there are two dialogues. There's the external dialogue to the community, to us. It needs to be simplified. We have to admit that health care is complex, but it can be branded and reshaped back to the community in a much better way. I would see the LHINs as being more empowered, not less empowered, bringing those pieces in under one single funding and planning umbrella and allowing the ministry, whoever's in power at the time, to do the strategic job of looking out over the top from a Canadian perspective and making sure that all the things required are there. But give the authority to the LHIN to pull the pieces, break those

barriers down and keep delivering a newly branded health care system.

The last piece on here I think that I would improve: Use the intellectual capital that you've built up by allowing the consumer in. We are a powerful voice; we do know health care. We have groups and organizations that are on the street. We work with front-line service delivery people. The LHIN could invite us in as intellectual capital as they redesign—and, by the way, quite frankly to the ministry as well on branding.

My thank-you here: These are real names of real people. I just pulled them off a list of 1,500 people that we've talked to in the last two years. Those people on the top line are people who have received enhanced services, either through community care, acute care, Home First, all the programs that have been driven out—GEM nurses, GAIN clinics etc. We need to rebrand them all, but they are benefactors of better health care in the last five years. The bottom line is a thank you to the LHIN staff because they invited us in.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have a little over three minutes left, and it's the PCs. Mr. Milligan.

Mr. Rob E. Milligan: Thank you very much for coming here this afternoon. I know it's a fair trek to come all the way from Ajax-Pickering.

I guess what I'm hearing more and more is that it's nice that you've been brought in with the Central East LHIN. It's the matter of providing different services within each LHIN. It seems to be that there's an inconsistency. That could be a direct result of demographic needs in certain regions within a LHIN. For instance, we heard from the Canadian Hearing Society that some—

Mr. Randy Filinski: But is the question on inconsistent services?

Mr. Rob E. Milligan: Yes.

Mr. Randy Filinski: Let me just—because I know my time will run out. All right? So that's the question.

I think the answer is enhanced capability. My third bullet, which I didn't really get to, is that it's a quality practice across the LHINs of consistent engagement and then a review of best practices on services. That includes branding. What tends to happen now is, everybody does something differently. Somebody needs to step back and brand these things so that whether I'm in Thunder Bay, Sudbury or Peterborough—I made a comment over here: If I get the flu in Pickering, it's probably the same flu I get in Thunder Bay, but I don't have to be told it's different or go to a different resource. This is a very important thing, but I think this is an enhancement to the LHINs: There are best practices that the 14 LHINs could adhere to.

Next question?

The Chair (Mr. Ernie Hardeman): That's it?

Mr. Rob E. Milligan: Yes.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

Mr. Randy Filinski: That's it? I get to go home?

The Chair (Mr. Ernie Hardeman): I didn't know that the flu was consistent everywhere, but now I do. Thanks, Randy.

MENTAL HEALTH SUPPORT NETWORK SOUTH EAST ONTARIO CORP.

The Chair (Mr. Ernie Hardeman): Our next presenter is the Mental Health Support Network South East Ontario: Garry Laws. Thank you very much for making the time to come and see us this afternoon. As with other presenters, you will have 15 minutes to make your presentation. You can use all or part of that for your presentation. If there's some time left over after the presentation, we will have some questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Garry Laws: Thank you for your attention. I am the system leader, or executive director, for Mental Health Support Network South East Ontario. I'm representing approximately 1,500 consumer-survivors, people living with mental health challenges, across this LHIN. We don't serve the Lanark area; we serve all other catchment areas of the southeast.

I wanted to sort of trace back a bit in terms of the LHIN, and the LHIN act specifically, and how this LHIN has been able to assist the consumer-survivors of the southeast. I came in as the executive director in 2009, which was the last of a second involuntary integration order. It was taking four very small consumer-survivor initiatives across the southeast and amalgamating them into one large organization, a regional organization.

At the time, of course, for the small organizations, I imagine it was a bit upsetting. I came in, again, with just the tail end of it to take on the Leeds-Grenville area. But what it did was give the consumers a very strong voice. I think, hindsight being what it is, it has really elevated our organization. It has elevated our board.

We have a regional board from across the southeast, representatives from all the different communities that we serve. We are a consumer-driven, consumer-led organization, which means that many to most of our board members are also self-disclosed folks living in recovery with a mental health and/or addiction issue. It really gave us an opportunity, as consumer-survivors, to provide peer support in each community as a cookie-cutter approach, however, having our own autonomy within each of the communities.

Each of our support centres—and we have eight of them across the southeast—didn't really change so much as the policy and good governance that has been provided by having one large organization. Standardized evidence-based practices are now the cornerstone of what we do. We only work with evidence-based programs such as the Wellness Recovery Action Plan and Intentional Peer Support. We really now have a strong organization that's very much supported, we feel, by this LHIN.

Initiatives such as the back-office integration project saved our organization about \$30,000 right off the top, and in a small organization, that is a lot of dollars that

went directly back into peer support. That actually represents almost two staff in one of our centres, so it really went to good use. It has facilitated many service integrations, and I think that one of the fine pieces of the act is that it really pushes us to that boundary of integrating our services into one system so that we're acting more as one and not as in the typical silo effect.

Reputably, we are shoulder-to-shoulder with our clinical partners and at the table. In fact, we were one of the consumer-survivor groups that was selected for our recent—we're still in the process—addiction and mental health redesign here in the southeast. The consumer voice was included at that table. That was, by the way, not just selected by our board but nominated by our peers from across the southeast, our clinical peers who saw the value in having the consumer voice heard at the table, so much so that our peer support is seen in the redesigned process as a very important foundational aspect of the care, treatment and recovery of people living with addictions and mental health issues. That was a huge, huge step for what was four small organizations that were really kind of fumbling along trying to organize themselves, within the communities that they were in, into one larger organization that spanned across the region and was one, solid, unified voice.

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It's brought performance indicators in. While they may not seem that exciting when you first get your arms around, it has actually really assisted and supported one particular area for our organization that was crafted into our board strategic plan, the reduction of stigma. That is pretty much what you see on a lot of the vision statements that the LHIN or the community coalitions set out: reducing stigma, eliminating stigma.

Mental Health Support Network put together a very cost-effective plan supported by the LHIN. We now have what's called the Elephant in the Room program, not just in the southeast, but it has trickled into three other LHINs. It's a very much asked-for program. We're out talking about mental illness and addiction issues in schools, through companies, to the military. CFB Trenton has adopted the program. Five thousand elephants across, really now, the province, which was really the foresight of putting stigma as a performance indicator, asking people to reduce and train our folks on stigma reduction, and taking it out to the public. It wasn't just an indicator for mental health and addictions agencies; we were able to take it and make it something of its own.

I guess one of the most important pieces of that is, it has allowed this organization, through the stigma reduction program, through the redesign process, to really become a forerunner in terms of peer support. We also have started, through a research project with Providence Care, a transitional discharge model, and that is actually just being launched formally today through Providence Care, where peer support is going to be matched up with someone being discharged from the hospital. The evidence proves that if it's done correctly and the match is a good match, that the person will be repatriated and not

have to go through the readmission process, and that the person will be supported and navigated through the system upon their discharge from hospital.

Just a few of the high points that I wanted to bring forward to this standing committee of what the LHIN act has done—and in this area, the South East LHIN has really strongly embraced and ensured that we, as an organization, a consumer, are very much heard. I would like to ensure that the folks here know that that is probably one of the highest pieces of respect that you can afford the folks in the southeast, people living with mental health and addictions—is to be heard. That is the greatest thing. We don't feel comfortable, perhaps, in other areas of our lives, so to have a LHIN respect the fact that we have a voice and we have patient experience that we can share with you as a system—that really begins to change not just the organization but people's lives.

With that, I will rest, and if you have any questions—

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about two minutes for each caucus. It starts with the third party. Ms. Gélinas.

M^{me} France Gélinas: Thank you so much for coming. As you know, we're reviewing the LHINs. I fully understand that because of the integration, you have a stronger voice. It's a very good story that you told us. What I want to know is: In the future, now that the integration piece has been done, do we still need the LHINs?

Mr. Garry Laws: Oh, yes. I mean, the integration piece was just one small part of the process. We have a LHIN here that encourages and enhances professional development. They're partners in the delivery of service, really, not necessarily just around integration orders.

M^{me} France Gélinas: Because other people talk about being clear as to where one's mandate ends and where, in your case, the service provider's mandate starts. You seem quite comfortable to have a bit of a grey zone there, where the LHINs also talk about human resources and community development etc., where others really want clear boundaries as to, "This is the LHIN's mandate. This is where it ends, and let us run our shop the way we want." You don't subscribe to that.

Mr. Garry Laws: What I subscribe to is that the LHIN does allow us to operate our organizations. As organizations, the board is the employer. What I do subscribe to is the global systems thinking and global unification of the LHINs as partners in the delivery, not in the actual service delivery but in ensuring that those performance indicators are met and upholding the values that come out of, in our case, the M-SAAs.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you so much for coming and for all the good work that you do, especially around the peer support piece. Many of us are very enthusiastic about the potential there.

Mr. Garry Laws: Good.

Ms. Helena Jaczek: Earlier today, we did hear from Providence Care mental health services, from front-line

workers. There was a concern there about, in essence, the move from institutional care to the community. You mentioned that you work with Providence Care. Have you seen, from your perspective, that the LHIN is aware of the difficulties in the system in terms of capacity, whether it be institutional or community-based? From what we've heard from you, you are a fan of the LHIN. But do you feel there really are sufficient opportunities to ensure that the LHIN hears concerns across mental health and addictions?

Mr. Garry Laws: Yes, I do.

Ms. Helena Jaczek: So you would say that if there is a move from institution to community, every effort is made to make that seamless?

Mr. Garry Laws: Every effort is made to make it seamless; every effort is made to ensure that the system is integrated, that the person is not left out there without the right supports and services. I think that is a major reason why we're looking at the redesign of addiction and mental health in the southeast and what is the best model. We're still in that stage, but I was on the redesign task force and the LHIN was excellent. I have to say, it was one of the—I've been a leader of non-profits for many, many years. I will say that the expert panellists we were able to have connection to, the folks that they brought in to assist us in making decisions around the patient experience, were really first-rate. I do think that they don't make arbitrary decisions, if that's what you're suggesting. I think whenever we've done a depopulation—and I've done three of them in the developmental world—there's always, always a lot of anxiety, especially from the move from institution to community. It may not work out as best for a particular individual, but if the right care and the right leadership is there and the right planning has been done, we've done it. I feel very comfortable.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Milligan?

Mr. Rob E. Milligan: Thank you very much again for coming. I heard you speak of some overlap: some of the work that you're doing in your LHIN has spilled over into three other LHINs, I believe you said. To what extent does your organization within your LHIN work in partnership with other LHINs and other service providers in those jurisdictions? What's the scope of the partnerships there? And is that a valued thing that you think your organization—or is this an initiative that you think the LHIN should take?

Mr. Garry Laws: To answer the question in terms of what the LHIN does with the other LHINs, that would be a long answer; I don't have enough time. I sit on a provincial—I'm actually the chair of the Provincial Consumer/Survivor LHIN Leads Network, so that's how they got involved with our Elephant in the Room program. They took it back to their LHIN catchment area, and their LHINs were supporting it.

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To answer that—how did they get connected to it?—we meet on a quarterly basis, as a provincial network. It

was actually a network that was developed many, many years ago. It was mandated by a minister at the time, so we were actually mandated to meet at least twice and up to four times a year.

It's a knowledge exchange; it's information-sharing so that in the mental health and addictions world, at a peer level, that information is shared. Many, many good things are being shared across, at that level.

The Chair (Mr. Ernie Hardeman): Thank you very much, and thank you very much for your presentation.

Mr. Garry Laws: Thank you.

MS. DEBORAH JODOIN

The Chair (Mr. Ernie Hardeman): Our next presenter is Deborah Jodoin. Welcome, and thank you very much for being here. You'll have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left over at the end of the presentation, we will have some questions and comments from the committee. With that, the next 15 minutes is yours.

Ms. Deborah Jodoin: Thank you very much. The surname is Jodoin.

I come from quite a different perspective than the presenters that I've heard. I don't read well from notes, so I'm just going to kind of talk off the cuff, and I might ramble a bit.

I'm a retired nurse. I nursed for 36 years, and that's partly what brought me here. I have worked on the front line. My last employment was 14 years with an assertive community treatment team—not in this LHIN; in another one.

I have concerns. I also have had experience with the LHIN. I was at some hearings in Ottawa in 2006, I guess it was, discussing the LHIN mandate. I remember that at the time, folks expressed concern that the changes that were coming about would lead to a lot of privatization and delisting and that there would be an erosion of the health care system that we know Canadians are so proud of and hold dear.

At that time, there was a lot of reassuring of the people who had concerns about the for-profit delivery of health care making inroads, that we really should relax, that that wasn't going to happen, and that there would be continuing dialogue with the community and with people who advocate for community members.

Exactly the concerns that were expressed by people at that time, and that I shared—those fears have come true with a vengeance.

The other situation I had, talking with the LHIN, was in another LHIN, the Champlain LHIN, and it was a community hall meeting. I don't remember how long ago it was. It was an exercise in frustration. It became apparent to the members of the community who were there, quite early in the evening, that it was more of a show than anything. We weren't listened to, and in fact, the whole emphasis seemed to be to steer the community members to some kind of a goal of support of the LHIN.

It was very frustrating. I remember, after that, reading the report; the LHIN had some kind of written report. It didn't reflect at all what happened that night.

I understand as well that this review of the LHINs is two years late. It was supposed to happen two years ago. So maybe, from my perspective, and that's just from listening today—I've got a lot of other things to say, and 15 minutes isn't long—this is not a bad start, but if the public input is three weeks, after something has been delayed for two years, you're not going to get a good sense of what's happening, not from people like me, but—I hate the word “consumers”—from community members, people who receive the care.

I just moved into the South East LHIN, and I have to say this: I changed family doctors, so I'm now a patient of the Country Roads health clinic. It's fantastic. I met with the director, and he has a really good relationship with the LHIN. He kind of made me promise that today I wouldn't badmouth that relationship.

It's an example of best practice, I would think. There are nurse practitioners, there's a dietitian, and they even have a program where folks who can't afford it can come in and have some dental work done. There are some good things. He tells me that his relationship with this gentleman back here is really good, so that's the South East LHIN.

Also, in terms of what happens in this area, I just moved in in August, and I became aware that there's a new Providence Care hospital—it's a P3—that is going to be built. This leads to another one of my concerns. The community was informed—often, I'm sure, people learned about what was happening with this new hospital by what they read in the paper. What was in the paper was a price tag of \$300 million. That's what people were told—or maybe as much as \$400 million for this new P3 hospital. After the contract was signed—and I have a copy here of the document—the price tag isn't \$300 million; it's \$900 million.

I wrote a letter to the editor that didn't get printed. When I go out to buy a car and somebody tells me that it's going to cost something, and then when I get the bill it's three times that amount, that's not right. It was not accurately portrayed to the community. I guess that's an example. There needs to really be an opportunity to go out and get the information from people.

The other thing I wanted to say, and I don't want to run out of time: My experience with the assertive community treatment team was amazing. It's a really good program. We made a difference in people's lives because we got to work with them over a long period. Some of the clients I worked with, I worked with for 14 years.

The change in the quality of life for those people was amazing. If they did go into hospital, they weren't in for as long. We would accompany them to emergency or wherever they needed to go. The program works. You've got to fund it properly.

There are times, too—there are a lot of bed cuts, and there's this moving people into the community and treating them into the community. Sometimes what's

needed for somebody who has a serious psychiatric illness is time—time in hospital. I'm not talking about a couple of weeks; for some people, it's a couple of years for them to stabilize in a safe place with meals, where they're not going to be vulnerable to all kinds of horrible things happening.

That's kind of gone. There's too much of an emphasis on pharmacology when some kind of supportive therapy is probably more effective and a whole lot cheaper. That was one of the other things I wanted to make sure that I said to you.

The big picture, stepping back: I read the Canada Health Act. I read the LHIN mandate. What else did I read? A letter from the doctors for publicly funded health care, recommendations for where changes could happen and what to be aware of in any kind of changes.

When you deliver health care for a profit, somebody is going to miss out. There's going to be money taken off for profit. Oftentimes it ends up being that the provider—the nurse or the practical nurse who provides care—doesn't get a decent wage.

The situation in home care is a mess. I actually didn't have a South East LHIN story to tell until last Saturday. I apologize for rambling, but this really is important. My son's friend is a nurse, and he works in the States. He works for an insurance company. We got talking, and I wanted to defend our Canadian system as being superior to the American system. Hopefully you all know that that, really, their outcomes are poorer; they spend more.

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He said, "You know what? I came up here. I had to see my"—his mother lives in Tweed. Her common-law partner, who's in his mid-80s, had some kind of hernia; I think he had an inguinal hernia. He had surgery, and he was sent home. He was sent home with no follow-up at home. The next appointment with his doctor was in a three-week period, and nobody gave him instructions about what he needed to do when he went home. He said, "That's deplorable." He's right; it is. The man ended up in a very serious condition, back in emergency. Hopefully, he was hospitalized, but he might not be, in today's situation. He might be sent home from hospital, and the follow-up might be inappropriate. There are stories like that all over, and you need to invite people in to tell you those stories.

Also, the issue of extra billing: I'm told, "Well, nobody's faced with extra billing." I know they are. I've been through it with clients with the ACT team. I suggest that if you really want to find out about extra billing, have a hotline and publicize it so people know. If you've had a problem, we need to know, because that's somebody breaking the law.

We really are going to be losing our system. The priority needs to be—I guess we have to be aware of costs. If you give billions of dollars away to big corporations in tax cuts, it does reduce the amount you have to spend on health care. But it's quality; we've got to be looking at quality and not just cutting. "Ever-increasing efficiencies": I remember when that was the mantra of

the LHIN. It meant cutting, and sometimes cutting indiscriminately, and giving money and being able to take from a not-for-profit and giving to a for-profit. How much profit are they making? I guess that's one thing: As a taxpayer, if my tax money is going into a for-profit corporation—and often now, it's big corporations from the States providing some care—I want to know where my money's going. I want to know how much money is spent on advertising and what their profit margins are.

The LHIN, I guess, is here. It would be nice if it actually did what it was set out to do, and if there was public input and there were people on the board, maybe, who were elected—if consumer groups that advocate for patients were invited to the table. I guess the South East LHIN does do some of that. There needs to be more. We really do need to guard our system.

I could talk for hours. I guess I come back to the first point: Please don't let this be the last time. If you've got nine months to evaluate the LHINs, and this is the last time that people like me have a chance to communicate with you, you've got a problem. You need to hear; you need to listen and go out and invite people in.

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Deborah Jodoin: Yes.

The Chair (Mr. Ernie Hardeman): We have about three minutes. The third party.

M^{me} France Gélinas: I'm most interested in the example that you gave us where the LHINs had held a meeting. There were consumers there so, obviously, people came—

Ms. Deborah Jodoin: I hate that word "consumers" too. I'm a citizen—

M^{me} France Gélinas: Okay, there were people there.

Ms. Deborah Jodoin: Yes.

M^{me} France Gélinas: There were people there so, obviously, whatever invitation went out, people got the invitation and came. But you felt that you were not listened to. What proof have you got that you were not?

Ms. Deborah Jodoin: Oh, you could talk with anybody that was at that meeting. It was in Cornwall. I could find out exactly when it was. I was talking yesterday, actually, with somebody else who was at the table with me about how frustrating it was.

M^{me} France Gélinas: What was the issue that you were talking about?

Ms. Deborah Jodoin: It was feedback to the LHIN.

M^{me} France Gélinas: On?

Ms. Deborah Jodoin: It's quite a while ago now. I guess we expressed concerns, probably, about things like competitive bidding for home care and how it's a race to the bottom and the service has just deteriorated. It might have been that. It might have been just closing beds and amalgamating services without a proper look at whether that was, in the long run, wise—probably a number of issues.

M^{me} France Gélinas: Okay, on a number of issues. You read the report, and you saw that your comments had not been captured adequately?

Ms. Deborah Jodoin: It was almost funny, if it hadn't been so serious. There was—I can't remember, quite frankly; that was quite a long time ago—but reference to the fact that there was a lot of criticism. You know how you can neutralize language, and something can be made so confusing that it's hard to not know it wasn't positive. It was that kind of minimizing the—

M^{me} France Gélinas: Has it improved since? Have you had the opportunity—did you receive other invitations to participate in a LHIN-led—

Ms. Deborah Jodoin: No, no.

M^{me} France Gélinas: You're off the list now?

Ms. Deborah Jodoin: Well, I don't know. I don't know. That was quite some time ago.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for your presentation. That does conclude the presentation, and we thank you very much for taking the time.

TOWN OF SMITHS FALLS

The Chair (Mr. Ernie Hardeman): The next presentation is the town of Smiths Falls. There was one cancellation prior to that—Kingston, Frontenac and Lennox and Addington Public Health—so the next one is the town of Smiths Falls: Dennis Staples, Mr. Mayor, sir. Your Worship, welcome. As with all the other delegations—the mayor is no different—you have 15 minutes to make your presentation. You can use any or all of your time—

Mr. Dennis Staples: I want to thank the Clerk for allowing me to have standing today. I just found out about this late Friday for another purpose, and thank you for the opportunity. I haven't had a chance to prepare notes. Normally, I speak, but I have some notes I'd like to read to the committee. I should add a thank you for allowing me to provide this input.

The others have provided some background in terms of our involvement with health care. Mine goes back to 1968, which is just about 46 years ago, and my involvement with my council is 29 years. So if you add that up, that's 75 years—not all together. Thank you for this opportunity.

My comments are going to be very general. I'm in support of the LHIN community model—whatever you want to call it; it's now known as LHIN—for a variety of reasons. In my humble view, in terms of my involvement with health care over a long period of time, the current model we have provides better planning, much better decision-making and public engagement at the local level, and that's the key in terms of meeting the needs of our communities. The needs of our communities are all different; I'm sure everyone would agree with that. It also provides greater opportunity for collaboration and finding best or great solutions of the many health care providers that exist in our areas. It's a complex area, as you probably all know. I expect that this same comment would be true of the other 13 LHINs in the province, of the total of 14.

The health care map is complex and daunting, especially for those who have to access it, have to navigate within the system. I firmly believe that the LHIN model provides an important remedy for system improvement, service response and good decision-making related to health care for the customer, client, patient, consumer—whatever the current terminology is—and also for the family as well, which is part of this navigation.

I also have a comment that is individualized in my case. Could this objective be successfully achieved in a centralized model? I worked in the centralized many years ago when I worked for the OPS as part of the Ministry of Health and, subsequent to that, community and social services. My humble view as a citizen and as a mayor and as one who has had experience with the current model—could this be successfully achieved in the corporate model, i.e. a centralized or Queen's Park model? It's my opinion that, no, we wouldn't do it as well.

The community model, i.e. the 14 LHINs, has been, in my view, truly effective and in my opinion, well and increasingly effective in determining the services required by our citizens. They differ in our various regions, even within our LHIN. It responds to local needs and priorities and also addresses the health care challenges and deals with the critical issue that I think we're all painfully aware of: allocating and determining the allocation of scarce health care resources.

The second part of my presentation is to give you an example of something that Smiths Falls has been involved with and I've been involved with personally.

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Our community is well known for job loss and all those other challenges, which I won't go into today. This is not the time for that. But about three or four years ago, when we were dealing with some significant economic challenges, in addition to that we had three local doctors who decided to leave. Two retired and one passed away. Smiths Falls is a community halfway between here in Ottawa. It's a community of 9,000. When I talk about Smiths Falls, I'm talking about Smiths Falls and area.

We had two local doctors retire and one unfortunately passed away. That impact created 5,000 to 7,000 citizens in Smiths Falls and area who found themselves without a doctor. That put a tremendous strain on our emergency room. One of our local doctors—I'm not proud to say this—had a plaque in their office, a poster, that said, "If you need a doctor, go to see the mayor of Smiths Falls. He has to solve that problem."

Well, we've done a good job of solving that problem by working with our LHIN and the other partners, and I'll tell you about that. It has put a tremendous strain on our community. A lot of those individuals are still without a doctor. We've had individuals who have chosen to leave Smiths Falls because their doctor is in another area. From an economic point of view we've had citizens choose not to live in Smiths Falls because they can't find a doctor. So I wanted to point that out as well.

The South East LHIN—when I first became aware of this, I made a phone call. It was on a cold day in January three or maybe four years ago, the day after January 1. My phone call was responded to within about 30 minutes by the gentleman sitting behind me—his staff. We said, “We have to solve this problem.” And we’ve done a good job of solving that problem.

Extra support has been provided for our emergency room to get us through this challenge—our emergency department at the Smiths Falls site, or Perth and Smiths Falls District Hospital. Our community health centre, located in Smiths Falls, was resourced to take on some vulnerable clients who are part of that 5,000 to 7,000.

We’ve also found a way that we can hopefully attract new doctors to our area. The young grads are looking at working in a practice where there are other doctors there in terms of mentoring, consultation and not faced with the challenge of setting up their own practice because of the tuition debt that they have going through medical school. So we’ve created, with the support of our local communities, our municipalities, a local developer and some funding from the South East LHIN, a turnkey operation that would hopefully be able to attract up to six or eight new doctors. That’s almost completed. That wouldn’t have happened without the support of what I’ve just described.

The final obstacle is recruiting new doctors, and we’re working on that as well. But what I wanted to say and allow some time for questions is that the model that we currently have in place, the LHIN, and in our particular case the South East LHIN, has absolutely been critical in assisting us working through those situations in terms of support, assistance and understanding. They continue to work with us as well.

My final plug for this is to say that this model provides an opportunity, an obligation and a responsibility to our citizens to work within the LHIN structure to ensure that good plans are developed, priorities are identified, responsible decisions are made and the various local health agencies are at the table to allow this to occur—our hospitals, community care access centres, mental health and palliative care.

Recently, within the last month, I attended a meeting in Smiths Falls of all these groups coming together looking at another initiative that’s under way that’s absolutely critical called health links. For some of these leaders it was the first time they had been in a room together. Would that have occurred without the structure that’s in place? In my opinion, no, it wouldn’t have.

I think this is an effective model to ensure that we continue to look at system improvement opportunities and local response to needs that are different throughout the province. That’s what I wanted to tell you this afternoon.

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, we have about seven minutes left. We’ll start with the government. Mr. Fraser.

Mr. John Fraser: Thank you, Mayor Staples. Thanks for coming to present today. What I’m really interested in

hearing, though, is a little bit more about this solution that you came up with around having family doctors. Now you’re at the recruitment stage, so how are you connecting with everybody on that?

Mr. Dennis Staples: For the past 20 years I’ve been mayor, I’m contacted three or four times a year to meet with a prospective new doc—these young docs. What we’ve discovered is that in terms of the doctors who are retiring, now they have huge caseloads of maybe 1,500, 2,000. In fact, one of our doctors who passed away had a huge caseload; we’re told 3,000 to 4,000.

The new docs want caseloads of 800 to 1,200. They want to have a life. They don’t want to incur debt. So we’ve heard consistently from these new docs in the last number of years that if there was a place where they could go and set up shop—it’s already there; the overhead is there; the diagnostic equipment, computers, technology; and, by the way, they work with other established doctors. It’s been described to us as a turnkey. That’s exactly what we’ve created. It’s just about to open.

Mr. John Fraser: How do you advertise, in terms of how do you connect with those potential doctors out there?

Mr. Dennis Staples: Well, recently—our director of economic development just retired. For the past four or five years, our town, through our economic development department, which we’ve totally supported, goes to these recruitment fairs. It’s called PARO fairs—the young grads. Currently, we have a list of about 125 potential graduates we’re working on to try and entice them to come to Smiths Falls, come and serve our area. So that’s one of the ways we’re doing it.

Also, the existing docs, through word of mouth, have their points of contact to say, “If you’re thinking about graduating, you might want to come to our community and have a look at what we have available.”

The other thing that’s really to our advantage is that through the Ontario government—we thank you all for your support in this—we’ve had a significant redevelopment of the Smiths Falls site of the Perth and Smiths Falls District Hospital, close to \$50 million. It’s wonderful, so that’s another attraction for us.

It’s a variety of efforts we’re doing to try to attract new grads and even existing doctors to consider our lifestyle, our way of life; and, by the way, we have a place for you to work in.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have to cut it there. Mr. Milligan?

Mr. Rob E. Milligan: Thank you very much for coming in. It’s always great to see that local municipal individuals like yourself, who represent the people, are as active as you are in recruiting health care providers. I guess that was sort of an area that I wanted to dive into as well. We’ve heard that, obviously, you’re in favour of the LHINs. Is there anything that you would recommend to improve upon, something that you feel obviously needs to be addressed within the LHIN model itself, not necessarily for just the southeast, but the rest of the province?

Mr. Dennis Staples: I'm going to answer that in a very general way. I would hope that there's continued support for this community or regional approach to health care. Now that's described as the LHIN.

The other thing I would hope, and I'm sure this communication linkage is there, is that if issues arise within a LHIN—I'll use the South East LHIN as an example—in terms of a pressure point, that those issues get forwarded to the Ministry of Health and Long-Term Care at a very senior level in terms of making adjustments and remedies in terms of a particular challenge within our LHIN that we can't address with existing resourcing, and hopefully that gets dealt with at a higher level. I think I would just ask that the system be supported and continued, because, in my view, with the examples that I've been involved with, it is serving a very useful purpose and making a much-needed difference.

The Chair (Mr. Ernie Hardeman): Thank you. Mr. Vanthof?

Mr. John Vanthof: Thank you, Mayor Staples, for coming in and giving us some of your insight. Coming from northern Ontario, we face a continuous shortage of doctors. I really appreciate your advocacy on that issue.

One thing I'd like to dig a little bit deeper on: your new turnkey facility, which I commend you on. How will the doctors be funded? Is it a family health team or a community health care centre?

Mr. Dennis Staples: I believe it's a family health team. But we also have a community health centre as well, a CHC in Smiths Falls. I should also add: A couple of years ago we were provided with the nurse practitioners' clinic as well. So we're looking at a variety of things to try to provide for the needs of our community and area.

Mr. John Vanthof: Because if there's one thing that we're still trying to get our heads around, and in my community we're trying to get our heads around, and I believe this committee as well, it's: What is the funding model that's best for doctors, for the community? A family health team is quite a bit different than a community health care centre.

Mr. Dennis Staples: I'm going to answer that by saying I'm not sure, and I would not make a guess. My concern is trying to provide the resources to our community to meet the needs, and then sort out the chapter and verse as a result of that.

Mr. John Vanthof: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, Mr. Mayor, for being here and making your presentation.

We're slightly ahead of time, and our last delegation is not yet here, so we will call a recess for a health break while we wait for the next deputation.

The committee recessed from 1429 to 1438.

ONTARIO HEALTH COALITION

The Chair (Mr. Ernie Hardeman): I call the meeting back to order. I was going to say that I believe our

late delegation has arrived, but that would be totally inappropriate. We're still ahead of time, but we very much appreciate that you have arrived and we can get on with having this delegation. Thank you very much for taking the time to come and talk to us today. We very much appreciate your willingness to do that.

As with all our delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time as you see fit. If at the end of your presentation there's some time left, we'll have some questions and comments from the committee. With that, the clock starts now and the next 15 minutes are all yours.

Ms. Natalie Mehra: Thank you very much.

The Chair (Mr. Ernie Hardeman): Before you start—we'll restart the clock—the delegation is the Ontario Health Coalition: Natalie Mehra, executive director. I should have introduced our guest; I totally forgot. With that, the clock starts now.

Ms. Natalie Mehra: Okay. Thanks for having me. I apologize for not being able to be at the hearing yesterday. Thank you for hearing from me today instead.

The Ontario Health Coalition's mandate is to protect public health care under the principles of the Canada Health Act. We have a network of local health coalitions across Ontario, 400 member organizations, and thousands of individuals committed to protecting public medicare. We've had extensive experience, both prior to the passage of the Local Health System Integration Act and since, in trying to work to preserve and improve single-tier public health care services across Ontario.

I struggled a little bit with this presentation because I didn't want to be too negative. Although there are obviously people within the local health integration networks who have great expertise and although there are individual projects within LHINs that do have the potential to—or do, actually—improve health care, overall we are concerned that since the passage of the local health integration network act, the fundamental principles of the public health care system have been eroded.

The other day, Bob Hepburn, one of the editorial opinion writers for the Toronto Star, wrote a column—it was rather a shocking column—in which he said that health care services have not been eroded in the way that they are now in more than a decade, since the deep cuts of the mid-1990s. That's a really big statement to make. I sat back and thought about it and tried to quantify: Where are we seeing cuts? To what extent is public access to services being eroded? In truth, that statement is justifiable by the evidence. Unfortunately, part of this, although not all of it, is under the purview of the LHINs and part of it is under the ministry's planning. I'm going to try and separate out what we see happening—quickly.

From our perspective, the fundamental role of a public health care system is to measure and try to plan to meet population need for health care. That's a fundamental role of the public system. We pool our resources through our taxes; we redistribute them out through free services at the point of need. The idea of that is that cost should not be a barrier to needed care. That, I believe, is sup-

ported by almost all Canadians and certainly all political parties in Canada. Therefore, the design of the public health system is supposed to meet these fundamental goals and principles.

However, what we've seen is that under the planning regime instituted and the extraordinary restructuring powers under the Local Health System Integration Act, these principles have been subverted to a command-and-control structure that has removed, in many cases, meaningful public input from decisions that affect the community; that institutes a planning system that actually bears no relation to community need for services; and has adopted an arbitrary integration imperative that is more ideological than it is evidence-based. In fact, while the LHINs are currently making some moves towards restructuring community health services, the prime accomplishment that they have made over the years has really been to enforce hospital cutbacks. These are very, very significant hospital cutbacks.

The LHINs' own accountability mechanisms to the ministry are themselves quite convoluted. The performance indicators are very few for the LHINs. There are 15 of them, actually, and they themselves are not enforceable. Many of them, actually, fall out of the LHINs' powers to actually address in a concrete way, but they're not enforced and they're not really enforceable. The LHINs also have a secondary process of integrated health services plans with a whole separate set of goals that they're also supposed to follow in their communities. Those goals don't necessarily match with the performance indicators. None of those flow from any kind of plan to measure and try and meet population need for health services.

This is what we've seen, in short: We've seen that in Ontario's health care system now, there is no capacity planning. This is a really fundamental problem. The last capacity planning that was done was in the 1990s under the health restructuring commission. Although we had issues with the bed targets at that time—they were set on Australian benchmarks—certainly, the process was one in which there was a clear plan for each community. The plan was published; there was opportunity for meaningful public input. The plan could be appealed on the basis of evidence. There was a whole process around that. None of that currently exists under the local health integration network planning system.

To date, the LHINs have engaged, and, without actual integration orders from the LHINs, hospitals themselves have engaged in an array of cutbacks that are ad hoc, that are not associated with population and need. What we've seen put at most risk now across Ontario are rural hospitals and rural health care services in particular; chronic care, or what they now call complex continuing care hospital beds; physiotherapy and rehabilitation services; an array of outpatient clinics, like pain clinics, that have been closed for entire regions; and the whole gamut of care that is longer-term care, which is now very severely rationed and very deeply privatized.

Our first concern is that under the LHINs legislation, the minister is supposed to have created a strategic plan for the health system. That strategic plan is supposed to have guided the LHINs' strategic plans for their own areas. So, like a pyramid, the vision and goals of the health system are supposed to flow out across the province. There should be central standards set, and then each of the regions follows those standards and develops its own health care system to meet the unique needs of their communities. There is a lot of good wording in the LHINs legislation around coordinating care and measuring and meting care and flowing the plans from this strategic plan.

However, the minister's strategic plan for health care—there was supposed to be a 10-year strategic plan created in 2004 after the legislation was passed. That plan never materialized. We were told by Elizabeth Witmer's staff at the time that Elizabeth Witmer had done a freedom-of-information request for that strategic plan and was told that it would not be released publicly, despite the fact that the legislation calls expressly for public release of the strategic plan. They were told that it was a cabinet document. We never found or were able to get a copy of that 10-year strategic plan. This was when George Smitherman was health minister.

Currently, there is another plan for health care: Ontario's Action Plan for Health Care. I don't know if that is supposed to be the strategic plan for health care, but if it is, it has very few concrete, actionable items in it. It has very few concrete goals. It doesn't follow the format set out in the LHINs legislation, with a vision and strategic goals to meet it, and so on, and in fact, isn't strong enough or clear enough or even concrete enough of a document to guide a health system for a province.

If you compare our planning regime to other jurisdictions—I'm going to run out of time—you'll see that other jurisdictions actually have bed studies for long-term care; they actually have bed studies for hospital care; they have benchmarks; they have occupancy rates that they try to meet. None of that exists in Ontario's health system.

In Ontario, we've seen an entire hospital closed in Shelburne. That decision never even went through the local health integration network. It didn't go through the integration process, where there's supposed to be a board motion—integrations, of course, defined as coordination, right through to closures and dissolution of health care services.

We've seen the entire closure of the health centre, the hospital—what remained of the hospital—in Burk's Falls, similarly treated as a department of the larger hospital, not recognized under the LHINs legislation as an entity unto itself because it's not a separate corporation. The whole community lost those services.

We've seen a so-called Hospital Improvement Plan required by the budget deficit in Niagara, which was prior to the requirement for the cuts plan—euphemistically called the Hospital Improvement Plan—a \$15-million deficit. The plan cost \$60 million. At the end of the day, this year, that hospital, after closing all of the

acute care beds, all the services and the emergency departments in two entire communities of 20,000 and 40,000 people—Port Colborne and Fort Erie—that hospital now faces a \$13-million deficit. The plan was never properly costed by the LHIN. There was no measure of new patient risk as a result of closing the vitally needed services in those community hospitals. There was no measure of increased costs on the municipalities. Tax increases had to actually be brought in in Niagara to pay for the increased ambulance costs in that community. There was no real, proper planning, and Niagara still has huge backlogs because of a lack of long-term-care beds and now a severe shortage of hospital beds.

We've seen in communities like Wallaceburg and Petrolia, where the local small and rural community hospitals are under constant risk of closure, again treated as departments of the larger hospitals because small and rural hospitals that are amalgamated to larger hospitals, under the LHINs' regime, are not considered to be separate entities.

And so, without any process whatsoever, either an unelected board of people in the LHINs, in the cases of Petrolia and Wallaceburg where the LHINs have intervened, or the hospital board itself, also an unelected group of people in the case of Shelburne and Burk's Falls, have arbitrarily decided to close down entire health care services for entire regions, with very superficial—if any—consideration for the consequence of cutting those services.

What we're seeing is that, at the bottom line, health system planning is now divorced from population need for care. That is a real problem. If regionalization was about measuring and trying to meet population need for care, about strong provincial standards and enforcing those, about embracing the uniqueness of each region of Ontario in the local health system and empowering local people to make decisions about that, and to give feedback about what's working and what's not, we could support it, but none of those things are actually happening under the local health integration networks.

We think that reform needs to follow a principled track that flows from the notion that the fundamental goal

of the health system is to measure and try to meet population need for care. So what we're recommending is that the extraordinary powers for restructuring be removed from the LHIN legislation—that nobody should be able to restructure or required to restructure in perpetuity anyway. It doesn't make any sense. It's demoralizing. It's damaging to the health system, and the LHINs have not shown that they have the capacity or the proper processes to engage in permanent health care restructuring. Even the Health Services Restructuring Commission in the 1990s had a sunset clause. It restructured for a number of years, and then it ended, and the system was able to rebuild to some extent again.

It should be needs-based, focused on the core goal of the health system. It should focus on equity. Public ownership and non-profit control should be embodied in the act; currently, the LHINs are able to transfer services to for-profit entities—the minister, under the act, is not, but the LHINs are able to.

They should be democratic, in keeping with our democratic traditions in terms of school boards, in terms of municipalities and, in fact, in terms of the provincial government. There should be concrete protections for patients against user fees, extra billing and cuts to medically needed health care services.

We don't have time to go into the rest of the details, so I will be happy to provide them in a written submission.

The Chair (Mr. Ernie Hardeman): Thank you very much for that. We have less than a minute left, so we will leave it at that.

We thank you very much for making your presentation. If you do leave a copy of your presentation, we will make sure that the committee has that in its entirety, so that it can be read for their deliberations.

Ms. Natalie Mehra: Thanks.

The Chair (Mr. Ernie Hardeman): Thank you again for being here. We very much appreciate the time you took.

That's the end of the deputations this afternoon. If there's nothing further, for the good of Rotary, this committee stands adjourned.

The committee adjourned at 1454.

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